COMPARATIVE STUDY ON COMMUNICATION STYLES AND SILENCING OF SELF IN INDIVIDUALS WITH AND WITHOUT DEPRESSION

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BY

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Dedicated

to

my family

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ABBREVIATIONS

BDI	Beck Depression Inventory
HAM-D	Hamilton Rating Scale for Depression
CSI	Communication Styles Inventory
STSS	Silencing The Self Scale
GHQ	General Health Questionnaire
EX	Expressiveness
PR	Preciseness
VA	Verbal Aggressiveness
QU	Questioningness
EMO	Emotionality
IM	Impression Manipulativeness
ESP	Externalized self-perception
CSS	Care as self-sacrifice
STS	Silencing the self
DS	Divided self
SES	Socio Economic Status
L	Lower
LM	Lower Middle
UL	Upper Lower
UM	Upper Middle

ABSTRACT

Introduction: Communication style is defined as the way in which one uses signals to process, interpret, filter, or understand literal meaning, it is observable, multifaceted, and though variable, it remains sufficiently patterned to create expectations. Jack's self-silencing theory holds that women form a concept of self based on participation in close, genuine relationships with valued others. Failed attempts to form or maintain these relationships can lead to an extreme, even pathological, set of cognitive schemas termed silencing the self. It has been conjectured that both communication styles and silencing of self play a role in manifestation and maintenance of depression, in different ways for both men and women.

Aim of Study: To study: 1. The gender differences between communication styles in individuals with depression and without depression

2. The gender differences between silencing of self in individuals with depression and without depression.

3. The relationship between communication styles in individuals with depression and without depression.

4. The relationship between silencing of self in individuals with depression and without depression.

Materials & Methods: The cross-sectional study will collect data via predesigned proforma for socio-demographic details and questionnaires. The questionnaires used will be – 1. Beck Depression Inventory 2. Hamilton Rating Scale for Depression 3. Communication Styles Inventory 4. Silencing the Self Scale 5. General Health Questionnaire - 12.

Results: Communication style used by depressed subjects was found to be questionningness and emotionality while for non-depressed was expressiveness. Depressed females yielded significant results on questionningness and emotionality while males on impression manipulativeness and emotionality. The non-depressed females showed higher impression manipulativeness and males expressiveness and preciseness. Overall, depressed subjects and in particular depressed males showed higher silencing of self.

Conclusion: There was significant difference between the communication styles and silencing of self in individuals with depression and those without.

Keywords: Communication styles, Silencing of self, depression, gender differences.

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INTRODUCTION

In a papyrus manuscript dated near the end of the third millennium B.C. the first recorded suicide threat was found [1]. This marked the beginning of man's struggle with depression which, 4,000 years later, continues to bedevil scientists and clinicians alike. Mankind is still battling with the problem of depression and man being a social animal, it is imperative that factors associated with development and maintenance of depression be studied. Through millenaries the phenomena related with depression have focalized attention of philosophers, theologians, and psychologists. The literature of depression is exhaustive and full of a concourse of orientations from which this construct has been studied and for most part, the existence of depression has been attributed to the sufferer. The enormous amount of literature is paralleled by the enormity of problem.

Psychological Literature Of Depression

The theories of depression have been augmented by intellectuals form psychoanalytic, ego-analytic, existential, cognitive, and behavioral schools. Some viewpoints are substantiated by research findings, and some have less successful empirical demonstration of their principles and may have stood for decades without any attempts at scientific validation of their tenets. An attempt at summarizing the basic tenets of the major theories and highlighting the facets of those theories with entailments for the intimate relationships of depressed person will be made in the following section. Major theories that will be addressed are psychoanalytic,[2,3] cognitive approach, several behavioural conceptualizations, including[4,5] model of learned helplessness. Briefly the concept of interpersonal depression will be discussed which will include an analysis of portion of literature pertaining to depression.

Psychoanalytic Theories of Depression

Psychoanalytic contributions about clinical depression have been extant for decades now. The theory has focused on the intrapsychic system, and whilst it is intellectually appealing, the supporting data comprise anecdotal,

individual case studies and are consequently not welcomed by much of scientific community. However, psychoanalytic conceptualizations have had, and continue to influence the understanding of and psychotherapeutic interventions with depressed individuals. Elemental to psychoanalytic formulation of depression is the construct of 'anger inward'[6,7] initially noted this attribute and held it responsible for impatience, envy and egocentricity seen in depression. In his classic paper, "Mourning and Melancholia", Freud in 1917, ascertained the self-reproaches of the depressed individual to be the chief characteristics distinguishing between clinical depression from normal grief:

"The distinguishing mental features of melancholia are a profoundly painful dejection, abrogation of interest in the outside world, loss of capacity to love, inhibition of all activity, and a lowering of the self-regarding feelings to a degree that finds utterance in self-reproaches and self-revilings, and culminates in a delusional expectation of punishment. This picture becomes a little more intelligible when we consider that with one exception, the same traits are met within grief. The fall in self-esteem is absent in grief; but otherwise the features are the same."

After reviewing the psychoanalytic literature of depression, Nugent[8] concludes that psychoanalytic theorists have unheeded early indictments in literature, of the intimates of depressed persons, as they are particularly concerned with the dynamics of the intrapsychic system. Psychoanalytically oriented minds are more concerned with the phenomenon of anger inward than the interpersonal circumstances which bring about the rage first off. Psychoanalysts are not concerned with 'what' results in depressed symptomatology, rather they seek to understand that 'why' when an event occurs the depressed does not draw back the libido from the love object and transfer it to a novel one.

Klein (1948)[9] suggests the depressed person to be greedy for love, frustrated, in rage, guilty and seldom successful in building and holding onto interpersonal relationships. Jacobson (1964, 1975) [10,11] also notes

that the anger and guilt keep the depressed form perceiving the intimates as lovable and ensuing despair over not being accepted and consequent intensification of the self-reproaching. Researchers [12] further render descriptions of the intimate relationships of the depressed. The extensive compilation of often observed interaction patterns of the adult depressed individual include; one or few highly dependent relationships marked by need for love and attention and in which the needs of the other are not realized. Reciprocity in such a relation is lacking; envy and competition are denied but find a way in feelings of inferiority and success only by the achievements of others. Additionally there is clinging and holding on ensuing need to control; intimates thus, become objects for manipulation and from whom only full acceptance is satisfactory. This piece of literature is significant for this study, as it provides the literature for descriptions of depressive style in intimate relationships.

Beck's Cognitive Model of Depression

The rendition of depression as an expression of aberrant cognitive processes[2,3] has found great attention in both clinical and research literature. Beck holds negative cognitive set to be the origin of depression. Of considerable importance to the Beck stance is the contestation that the negative affect is secondary to cognitive considerations. This viewpoint describes the cognitive style of the depressed as a negative triad; that includes negative views of self, negative views of the world and negative anticipation of the future. The cognitive school offers hypotheses that can be tested, thus allowing empirical investigations. Extensive reviews of research pertaining to the cognitive model of depression have been put forth by various researchers[3,8,13] .

Endeavour to develop an empirically deduced description of depressive symptomatology[14,15] led to the formulation of Beck’s cognitive model. It was noticed [16] that when confronted with a state of affairs which could be interpreted as a loss, reactions of depressives and non depressives were different in that, for the depressives the genuine loss situations were

misconceived or exaggerated and over-generalized. The frequency of generalizations, discretionary inferences, and magnifications led to the conclusion that cognitive instead of affective problems were at the centre of the matter. The cognitive model puts forward five qualities of the depressive cognitive style that maintain and intensify the troubles. They are – low self esteem, self-reproach and self-criticism, pessimism, snowballing of sadness and apathy and changes in levels of motivation.

Most of the empirical research postulates that the depressed perceives themselves as failure and as someone who lost something of value[15,16]. Various studies [17-19] have shown that negative cognitions, as described by Beck, can be markedly correlated with the intensity of depression.

While Beck's model is more useful than psychoanalytic conceptualization in that it is conformable by experimental measures, the theory remains nevertheless, an argument that intrapsychic phenomena are at last at the root of the problem. Fundamentally, the assertion is that depressive symptomatology may be brought about by external events; it is the individual perception and appraisal of the situation which results in depression. The cognitive model does not attempt to infer as to why such misdirection become the preferable way of handling the precipitating issue.

Learned Helplessness and Depression

The original theoretical view[20,21] was that when inescapable aversive stimulation is faced, people fail to learn in subsequent situations where escape and/or avoidance are possible. Fundamental to this theory is the construct of interdependency between behaviour and its outcomes.

Abramson, Seligman, and Teasdale[22] proposed a reformulation of the model, based to a predominately upon attribution theory. The revised hypotheses related to depression are:

1. Depression consists of four classes of deficits: motivational, cognitive, selfesteem, and affective.

2. When highly desired outcomes are believed improbable or highly aversive outcome are believed probable, and the individual expects that no response in his repertoire will change their likelihood, (helplessness) depression results.

3. The generality of the depressive deficits will depend on the globality of the attribution for helplessness, the chronicity of the depression deficits will depend on the stability of the attribution for helplessness, and whether self-esteem is lov/ered will depend on the internality of the attribution for helplessness.

4. The intensity of the deficits depends on the strength, or certainty, of the expectation of uncontrollability and, in the case of the affective and self-esteem deficits, on the importance of the outcome" (p. 68).

The preponderance of perception of helplessness has existed in literature of depression for long enough now. Research investigators [23] reported that feelings and attitudes oft reported by depressives are those of helplessness and hopelessness. Though the theory of learned helplessness is largely accepted, it should be noted that research pertaining to this theory has been largely based on laboratory manipulations. The experimental tasks employed during trials ((i.e., noise, anagrams, etc.) do not bear much resemblance to real life situations. Seligman[4,5] mentions several examples as being out of control and capable of precipitating depressive episodes (i.e., death of a close one, separation, physical disease, and aging). Since Freud[24], however, it has been noticed that all individuals who suffer these adversities do not become clinically depressed. Further, the histories of many depressed patients do not show the presence of any of these events.

Behavioral Approaches to Depression

The literature of behavioral school includes a heterogeneous group of theorists putting forth several conceptualizations which are sometimes complimenting to one another and at others contradictory. This brief discussion will provide a cursory rundown of the general behavioral

propositions. Both Skinner and Lazarus[25,26] have depicted depression as a debilitation of one's behavioral repertoire as a consequence of insufficient positive reinforcement.

Multiple other researches [27-29] which purport the depressive as having insufficient social skills. For these studies, only the interactional behavior of the depressive was investigated and possible contributions by the intimate of the depressed person were not considered.

Interpersonal Approaches to Depression

The aforementioned schools appear different from one another as one focuses upon intrapsychic phenomena and others on cognitions or behaviors. However, they bear one resemblance that they have studied the depressed individual in relative isolation. There is a small collection of theories which attends to the conceptualization that depression as an attribute of some interactional system. Attempts to understand "the depressive in his/her relationships" [30-32] comprise the premise that it is only the behavior of the depressed partner which is in some way aberrant. Weissman and Paykel (1974)[33] have studied the levels of environmental adjustment for depressed women. They report marital difficulty as the most commonly reported problem among their depressed subjects.

The intimates of suicide attempters were delineated by Tabachnick in psychoanalytic terms. He refers to depressive and intimate mutualism as being based on social features of dependency, sadism, and masochism. For the depressed intimate, the non-depressed partners are characterized as ready and eager to be placed on the precise reciprocal [34].

The bond is presented as one of reciprocal punishment; because of his/her own unrealized dependent desires and their inability to express anger over giving, the intimate is angry with the established patient.

Conversely, by inordinate demands and by his/her masochistic woes, the depressed partner penalizes the intimate by incriminating the intimate for not giving enough at the meta-communicational stage. Tabachnick concludes that with their dynamics, both spouses are expected to manifest

and sustain the symptoms attributed to depressed people. There are three theories of interpersonal depression[8,35,36] based upon the constructs of communication theory[37]. The theory of communication is a set of constructs derived from cybernetics[38] , that emphasize homeostasis and feedback mechanisms; the theory of information[39] about signal input-output; and the theory of general systems[40] that focuses on the whole system and its elements' relationships, and not on individual elements in isolation. The principle common to all these methods is that the concept of simple linear causality appears to be dismissed.

Communication styles

Communication style is determined as the way in which one uses signals to process, interpret, filter, or understand literal meaning[41]. Norton affirmed that communication style is observable, multifaceted, and though variable, it remains essentially patterned to make expectations. There are several ways in which interpersonal communication can be defined; some scholars have defined interpersonal communication based on the situation and number of participants involved[42], thus referring to the interaction between two individuals which are in close proximity and can give immediate feedback and employ multiple senses. However, interpersonal communication is a different form of human communication that is defined not just by the number of people communicating, but also by the quality of the communication. Interpersonal communication concerns with the exchange of messages, verbal and nonverbal, between people, irrespective of their relationship. Thus, interpersonal communication involves the exchange of messages in all kinds of relationships, ranging from functional to causal to intimate[43]. Interpersonal interaction is used through social interaction to accomplish personal objectives[44]. These definitions all represent interpersonal communication as postulating some form of common activity, interaction, or exchange, but they also differ significantly. Various researchers have defined interpersonal communication in different ways

such; interpersonal communication occurs in close relationships[45], interpersonal communication is any exchange of messages between people[43], interpersonal communication is a way for reaching personal goals [44].

Communication styles are known to act upon the social experience of people, therefore making it an all-important facet to be studied. Having said this, communication styles become all the more essential because of their practical relevance in all kinds of contexts that involve the transfer of personal and non-personal information, ideas, knowledge and feelings.

Parent-child interaction pattern is considered to be the basis of the emotional development of children and this is reflected throughout their lives. The manner in which families express themselves to one another is varied. Fitzpatrick[46] recognized two basic dimensions of conversation and conformity in family communication patterns by examining McLeod and Chaffee's theory[47]. The construct of conformity preference is the amount of pressure the families puts on members to assimilate tendencies, values and beliefs[48]. These families have a traditional build, where parents expect members to do things in harmony with their parents' wishes[49]. Another attribute of this model is conversation, which pertains to an environment where family members are urged to engage in spontaneous interactions and take part in open and free discussions on various topics and new ideas[48]. Since the communication patterns of the family influence emotional development of a child, the communication styles that a child will employ later in life can be safely considered to be ingrained in childhood experiences.

In order to incur an empirically based model of communication styles, De Vries & Bakker Pieper, et al.[50] conducted a lexical study utilizing adjectives and verbs that depicted the manner in which people communicate. The chief premise of a lexical study is that anything that can be said on the manner in which someone communicates must get encoded in language and recorded in a dictionary. Using an extensive list

of 744 adjectives and 837 verbs, researchers provided preliminary evidence for seven communication style dimensions was provided. These lexical communication dimensions were named Expressiveness, Niceness, Preciseness, Supportiveness, Emotionality, Threateningness and Reflectiveness. The description of these is given below:

- Expressiveness - It relates to a person who, when they speak, is very demonstrative and can mask their facial expressions and emotions.
- Niceness – They are the individual who typically gives information to others, makes others feel relaxed with the situation of interaction, and is generally in a good mood for speaking.
- Preciseness – They are the people who know exactly what to expect from a situation, mark the important details, have strong skills in asking questions so that in any situation they get the right information and hold their opinions.
- Supportiveness – It refers to a person who supports the ideas of others whether or not they agree with them and when they talk and support the point of view and take into account the ideas of others when making a decision, they typically do not interrupt others.
- Emotionality – These individuals usually transmit a wide range of emotions when they communicate, are easily alarmed, rush into drawing hasty conclusions based on their emotions and sometimes cannot hold a conversation because of their emotions. Such an individual is simply put, an emotional person.
- Threateningness – It refers to an individual who, when speaking, often raises his or her voice, is verbally abusive, often interrupts others, and does not let others speak.
- Reflectiveness – It refers to a person who, before speaking, often thinks twice, takes into account all the information before forming an opinion on a specific topic, is analytical and can be characterized by profundity in their opinions.

Empirical findings suggest that depression and marital distress are in some way interlinked with the manner in which couples communicate. Distressed couples are suggested to communicate in a different manner as compared to their non-distressed counterparts in several ways (see Weiss & Heyman, 1997 for a review)[51]. Including the enhanced levels of negativity, reduced levels of positivity and marred problem-solving, distressed spouses tend to interact with each other using the demand/withdraw pattern. This pattern surfaces when one spouse complaints or requests for a change and the other avoids or withdraws from the discussion, presumptively to avoid arguments or having to make the change being asked for[52]. In conflicted couples, wives often take on the demanding role and husbands take on the withdrawing role, especially when discussing changes that the wife would wish for in the relationship[53].

Akin to relationship distress, depression has been seen to have an impact on various aspects of interpersonal communication[54]. Depressed individuals have been established to engage in greater levels of reassurance seeking and negative feedback seeking[55-57] , to be more self punditry in their interpersonal demeanour (Blumberg & Hokanson, 1983[58]), restricted, passive, and under-responsive[59]; Lewinsohn & Shafer, 1971[60], and helpless, pessimistic, vulnerable, and mostly negative in the content of their statements [61,62] in relation with non–depressed individuals. These findings have been found for self–report instruments, interaction partner reports, and objective observer reports [62].

Self silencing and depression

The prevalence rate for mood disorders in India was 2.9%, with rate for women being higher (3.1%) than men (2.6%), according to National Mental Health Survey of India 2015-16. The aforementioned prominent theories such as Beck's cognitive theory of depression[63] and the hopelessness model of depression[64] are effectual in explaining the thought processes and experiences that create and maintain depression,

but are not sufficient enough to explain the gender differences in rates of the disorder. [65] It is conjectured that a self-silencing schema, believed to be specific to women may help to explicate gender differences observed in depression. Before delving into the theory of self-silencing, a brief discussion on 'self' is called for.

The notion of self

The construct of self has beguiled psychologists, philosophers, spiritual leaders, and thinkers alike. Nonetheless, the journey of self in psychology formally commenced with Wilhelm Preyer (1841–1897), who first mentioned 'self' in his book 'Die Seele des Kindes' (The mind of the child). In his work the development of self was largely dealt in the context of children[66]. Self also kindled the interest of pragmatists like William James (1890)[67], who conceived it, as a 'fluctuating material'. He summed up self of a person as 'the sum total of all that he can call his' [66]. His contribution pioneered research in self-concept and his categorization of self into social self, spiritual self, and material self has provided to the hierarchical model of self-concept[68].

Cooley[69], through the construct of looking-glass self, proposes an impossibility of experiencing the sense of self without drawing its connection with the others. Therefore, self can only be tacit in the context of 'the others' or the society in the backdrop. Similarly, Mead[70] in his book 'Mind, Self, and Society', stressed on the social facet of self by defining it as 'essentially a social structure and it arises in social experience'. Although multiple viewpoints are available for the theorization of self, the notion is often considered as being culture-bound or 'one of the central ideas in Western thought'[71]. In non-western cultures, the self is thought largely to be socio-centric [72] and is qualified by 'ensembled individualism'[73] instead of the extreme self-centered nature that is prevalent in Western societies.

In addition to culture, psychologists have been in concord that self-construal might also differ between males and females. Miller[71] for

example, has reckoned the earlier theories of self to be a 'man-made' concept, meant to describe an internal mental representation' (p. 14). She contends that the conventional construct of self cannot successfully portray female psychology since it disregards the importance of 'interaction' which is an essential part of the female psyche. She suggests that during developmental phase, girls' mental representation is constructed not through the process of separation but through the gradual maturation of a sense of 'agency through communication'. This standpoint is in harmony with Gilligan's [74] discernment of women's self and morality that includes the subjects of responsibility, relationships, and care. Reverberating these theorists, Surrey (1985) [75] put forth a theory of self-in-relation, which describes that 'self develops out of women's involvement in progressively complex relationships, characterized by mutual identifications, attention to the interplay between each other's emotions and caring about the process and activity of relationship' [76]. Women's relational self[75] has three core features: interest and attention to the others to have emotional connectedness, the anticipation of mutual empathic process, and expectation of relationship.

Self-silencing theory

Jack [65] theorized that self silencing, believed to be specific to women can explain the gender differences in prevalence of depression. Self-silencing theory by Jack, also imbibe some assumptions of attachment theory[77] and relational-self theory[75] for explaining the significant gender gap in depression[78] .

Jack's[64] fundamentals of self-silencing theory were based on her longitudinal work with clinically depressed women. Based on her experience, she gestated self-silencing as a relational strategy where women, to hold on to intimate relationships, 'silence certain feelings, thoughts, and actions'. Jack's (Jack and Dill, 1992)[79] self-silencing theory holds that women form a concept of self based on involvement in close, genuine relationships with valued others. When efforts to sustain or

establish such relationships fail, one's sense of esteem and identity can be discredited. They explained how, in their lives, silencing their voices led to a loss of self and a feeling of being lost. They also shared their guilt, hopelessness, and frustration over emotions of confinement and self-betrayal. However, self-silencing is not independent of the social structure rather has its origin in the gender norms prescribed by the culture. The inner dialogues of depressed women had self-monitoring and negative self-evaluation in arguments between the ''I'' (i.e., a voice of the self) and the ''Over-Eye'' (i.e., the social, moralist voice that condemns the self for leaving the "shoulds " culturally prescribed) [78] .

The social reality of women's subordination, the experience of becoming a victim of male violence, and the difficulties of financial dependency and poverty, reinforce the imperatives of Over- Eye's about women's goodness. In an effort to sustain relationships, women's inner arguments about how they should behave and feel have exposed a divided self that results from self-silencing. Inwardly, though outwardly projecting a pleasing, obedient self, they endured rage and frustration trying to live up to a good woman's cultural expectations in the midst of fraying marriages, abuse, and lives that were falling apart.

This egresses from an attempt to 'fill a gender role marked by passivity, body shame, fear and vulnerability, and niceness'[78]. Caught between a need for close, empathic relationships and living in a culture that does not reward such an orientation, women learn to repress or silence part of their self. In other words, self-silencing grows as women adopt cultural schemas about their proper role and behavior in intimate relationships which run counter to their need for connectedness. Silencing behaviors include putting the needs of others first, censoring and repressing genuine emotion, and judging self by external standards. As such, self-denial and silencing lead to the eventual loss of self, and this loss renders one vulnerable to depression (and their respective symptoms) in women. Though the common viewpoint is that silencing of self is relatively

common in women, some studies posit that men show equal and sometimes higher levels of self silencing.

AIMS & OBJECTIVES

To study:

1. The gender differences between communication styles in individuals with and without depression
2. The gender differences between silencing of self in individuals with and without depression.
3. The relationship between communication styles in individuals with and without depression.
4. The relationship between silencing of self in individuals with and without depression.

REVIEW OF LITERATURE

Depression:

Much research has focused on a diathesis-stress paradigm to explain the etiology of depression. According to diathesis-stress models of depression, personality or cognitive styles are thought to interact with environmental variables to create a risk of depression[80]. Some people are susceptible to experiencing depressive symptoms, but this susceptibility alone is not adequate to predict depression.Depression is only caused if these susceptible people encounter relevant adverse life events or stressors instead[80-84]. Support for diathesis-stress models has been mixed, and even when supported, they account for relatively limited portions of variance in depressive symptoms [85,86]. The gender gap in depression was highlighted, noting that about twice as often women experience depression among adults in clinical and community samples as men[87]. Following this seminalpaper, there was a proliferation of research and theories on gender differences in depression[87,88]. Research consistently shows that women are twice as likely as men to develop depressive symptoms[89]. The gender discrepancy in depression is an all important health disparity. Women are more inclined to describe themselves in terms of their interactions with others than men. [90-93]. Furthermore, girls and women are more likely to experience interpersonal distress than boys and men, including both difficulties with their relationships with friends and family and disagreements with their friends and relatives[94-97]. These interactions mean that, through increased exposure to interpersonal stressors, increased reactivity to interpersonal stress, or both, women are at higher risk of depression than men[98-100]. Researchers include interpersonal causes, and suicidal symptoms are investigated by questioning assumptions regarding one's interpersonal interaction skills. This views in competence are also measured using domain-specific self-worth measures[101-103] . The underlying idea is that seeing the self as good in relationships is correlated with strong self-

confidence, while seeing the self as failing in relationships leads to low self-confidence and a rise in depressive symptoms[104-106]. Findings are also inconsistent on peer and social competence as an indicator of depressive symptoms. Although there is an association between peer/social competence and depressive symptoms [104,107], low perceived competence in social and peer relationship skills tend to predict depressive symptoms for only some individuals[105]. Other research has not found that perceived peer/social competence predicts signs of depression over time [108-110]. Crocker [111] suggests that raises and declines of momentary self-esteem are a risk factor for experiencing depressive symptoms rather than having chronically poor self-esteem. Roberts and Monroe[112] found evidence for this argument. Although global self-esteem predicted increases in depressive symptoms, it contributed only marginally to the prediction of depressive symptoms and did not appear to predict changes in depressive symptoms over time. In comparison, the combination of high variance in self-esteem and high life burden tends to have the greatest effect on depressive symptoms[113-116] . Excessive reassurance seeking is one interpersonal behaviour that has been posited to play a role in the self-propagating cycle of depression, described as "the tendency to repeatedly seek assurance from others about value and lovability, irrespective of whether such assurance has already been provided"[117] . Research shows that the experience of interpersonal stressors contributes to increases in the quest for undue reassurance seeking[118]. There is also a positive relation between excessive reassurance seeking and depressive symptoms[119-122] . Excessive reassurance often correlates with negative stressors to anticipate changes in signs of depression[123-125] .There is also some evidence that persons with depressive symptoms produce emotional rejection only to the degree that they indulge in unnecessary reassurance seeking[126].

However, amid arguments that the gender gap in depression is one of the most robust findings in studies on psychopathology[88], depression is a global health priority. According to the (World Health Organization 2016), depression accounts for fully 10 percent of the total non-fatal disease burden worldwide.

Communication styles:

Beginning with Abraham[6] and more completely articulated by Freud [24], the self -devaluative tendencies of the depressive have been endlessly examined. Modern psychoanalytic theorists have paid little attention to Freud's suggestion that the symptomatically articulated grievances are, in fact, allegations relative to his/her intimate activities (communications). Distressed couples with a depressed partner have been found generally to communicate more negatively and less positively to demonstrate more aggressiveness[127-130] and to exhibit fewer problem–solving behaviors and to be less effective problem–solvers than distressed couples without a depressed partner[131]. In treatment studies of depressed psychiatric inpatients and outpatients, a link between marital distress and depression was also found [131,132].

Distressed couples have been found to interact in many dimensions differently than their non-distressed counterparts [87]. In contrast to non-distressed couples, distressed couples typically exhibit higher levels of negativity and reduced levels of positivity in their everyday interactions and in attempts to solve problems[133].Research has shown that language is used differently by women and men [134]. They continue to demonstrate that when they speak to people, women use signals of courtesy and they show respect by listening and recalling what has been said. Shakeshaft[135] claims that their speech is less likely to be based on impersonal subject matter, more on emotional and personal matters, and they speak less and listen more than men when women talk. In addition, it is observed that women's communication style has been regarded as "deficient". Communicative styles for women are often associated with

powerlessness, whereas communicative styles for men are often associated with professionalism and power[136]. When verbally speaking, women prefer to use a style of speech that gives the appearance of politeness more often than men. Holmes and Coates[137,138] refer to women as more polite than men when all the necessary reservations and qualifications have been taken into account. Politeness is referred to as 'women styles'[139]. Holmes[137] goes on to show that women are better than men in terms of verbal skills, especially initially. Further women have a tendency to convert statements into questions when communicating [140,141]. In general, it is argued that women apologize more often than men. In fact it has been pointed out that women even apologize for conditions for which they are not responsible[142]. Mills [1995] conducted a thorough study in New Zealand about apologies and the findings attempt to explain the differences with regards to how often, and how differently women and men apologize. No significant differences in the distribution of apologies used by women and men were shown in the study[143-145]. Academic research on psychological gender differences shows that while women use communication as a tool to strengthen social connections and build relationships, men use language to exert dominance and achieve tangible benefits[146,147]. Overall, women in conversation are more expressive, tentative and polite, while men are more assertive and power-hungry [148]. Men and women also differ in their relationshipswith others in society: while women tend to be more social and cooperative in their interactions with others, men value their independence [149,150].

Most of the research that looked at the social patterns of depressed couples have found communication variations that can be related to depression. There are also several studies that have failed to discover such differences. A couple of researchers [151,152] attempted to assay and extend the findings of Biglan et al.[153] in their earlier work, where distressed couples were contrasted with a depressed spouse, non-marital distressed couples without a depressed partner, and non-marital

distressed couples with a depressed partner, they failed to include martially distressed couples in their design without a depressed partner. Maritally distressed couples without a depressed partner were involved in both replication attempts and did not produce any substantial variations in relationship patterns that were unambiguously due to depression[151,152]. In addition, research investigating the relative contributions to self-reported demand/withdraw contact of relationship dissatisfaction and depression have failed to identify a unique impact on depression[154]. The failure to find a connection between depressions and demand/withdraw is especially surprising considering the similarities between the interpersonal model of depression[155] and the pattern of behavior in demand/withdraw[156].

Silencing of self:

The silencing of the self-theory[65], which postulates that more women than men are depressed because of their greater propensity to self-silence in intimate relationships in order to maintain peace and relationship and stick to the conventional female role, is one of the recent explanations for the sex differential. Failure to attain and maintain intimate ties can result in feelings of shame, guilt, and depression [65,157,158]. The predominance of women among the depressed has generated several explanations to account for the sex differential[88]. A mediational model[159] explored the interrelation between self-silencing, depression, and isolation in understanding the complexity. Respondents (some in intimate relationships) completed measures of loneliness, self-silencing, depressive experiences, as well as self-criticism, and dependency. Self-silencing served as a major mediator in the relationship between isolation and self-criticism after accounting for individual differences in depression. The authors concluded that self-silencing formed a critical bridge between depression and isolation. Depression has been related empirically to self-concealment, the degree to which individuals withhold negative personal information[160]. The fact that certain people hold distressing data to

themselves indicates why depressive symptoms increase [161]. Research has consistently shown that low-level self-concealment increases personal relationship satisfaction, whether married or not [162,163]. Self-silencing, which involves the concealment of one's true feelings from others, can lead to a sense of divided self where in the compliant self that is presented on the outside is incongruent with the personal feelings on the inside. The sense of divided self may be followed by feelings of anger and self-condemnation that in some women may lead to increased vulnerability to depression [164]. Gender-specific prohibitions against displays of anger and aggression in females further deter the expression of such feelings [164]. Women are socialized to put a heavy focus on experiences as they are a key component of the identification and emotional function of the female sex role. Greater self-silencing in women has been found to relate to greater depression[79,165-167] less marital satisfaction[168] and greater perception of marital partner as critical or intolerant[166]. Jack[65] conceptualized that self-silencing is not independent of the social structure but is deeply embedded in the culture's prescribed gender norms. This arises from an attempt to 'fill a gender role marked by passivity, body shame, fear and vulnerability, and niceness' [78]. In many studies, men reported levels of self-silencing equal to those of women [79,169] or even higher than women's [165,168,170-172]. Researchers have also found that while males experience substantially greater self-silencing than females, males also report reduced depression [171,173]. These outcomes have led to the conclusion that further analysis is needed of the reasons why men and women self-silence, and the implications of this distinction for psychological well-being [170,174].

RESEARCH GAP

There is paucity of literature that examines the communication styles of depressed individuals. There is impressive amount of literature analyzing communication styles between couples and parent and their children but, not much is studied about the general communications styles of the

individuals and how they differ among depressed and non-depressed individuals of the either gender. The studies in regards to silencing of self are not many in number and those which the researcher came across yielded contrasting results in terms of gender differences. The present study also aims to add to the existing pool of knowledge, especially in regards to the Indian context, as there still is a need of in-depth studies that examine this relationship communication styles and communication styles in depressed and non-depressed individuals as well as the gender differences.

MOTIVATION FOR THE STUDY

Due to the paucity of literature about communication styles and its relationship with depression, assessment in connection with it is required. Silencing of self is a hallmark feature of depression, so studying it would be beneficial and would also aid in psychotherapeutic intervention. The available literature calls for further exploration of the consequences of self-silencing in men and women with depression, especially in Indian context.

It would be beneficial to study the ways in which communication styles and silencing of self are related to depression, as it will help us to get better insights into depression and help us in determining the prognosis.

The existing literature on these variables calls for an in-depth study of variables and their sub-scales.

MATERIALS AND METHODS

Research Design: The present study employed the cross-sectional study design. The sample for the study group was collected from DMCH, Ludhiana and the sample for the control group was collected from the general population.

Source of data

The study was conducted on 100 patients undergoing treatment for depression (for study group) from Department of Psychiatry and Clinical Psychology at Dayanand Medical College and Hospital and on 100 subjects who were not undergoing treatment for depression and did not have symptoms of depression (for control group) from the general population of the age range 18-60 years.

METHOD OF COLLECTION OF DATA

Sample collection

This present study was conducted on 100 patients undergoing treatment for depression from the department of Psychiatry and Clinical Psychology, Dayanand Medical College and Hospital, Ludhiana. The data for the control group comprised of 100 subjects was collected from the general population. The age range for both the groups was 18-60 years.

SAMPLE SIZE: A total of 200 subjects of either gender were selected. A total of 100 subjects (50 males and 50 females) constituted the study group and a total of 100 subjects (50 males and 50 females) constituted the control group.

INCLUSION CRITERIA FOR STUDY GROUP-

1. Individuals of either gender will be selected for the study.
2. The patients with a diagnosis of moderate depression.
3. The patients with a diagnosis of severe depression.

EXCLUSION CRITERIA FOR STUDY GROUP-

1. Individuals of either gender having a diagnosis of mild depression.
2. Individuals with any other major Psychiatric Illness.
3. Individuals with any organic illness/condition.

INCLUSION CRITERIA FOR CONTROL GROUP-

1. Individuals of either gender will be selected for the study.
2. The individuals without a diagnosis of moderate depression.
3. The individuals without a diagnosis of severe depression.

EXCLUSION CRITERIA FOR CONTROL GROUP-

1. Individuals of either gender having a diagnosis of mild depression.
2. Individuals with any other major Psychiatric illness.
3. Individuals with any organic illness/condition.

METHODOLOGY

The study was conducted on 100 patients (50 males and 50 females) with the diagnosis of depression and 100 healthy subjects (50 males and 50 females) from the general population of the age range 18-60 years, after taking an informed consent in written. Socio demographic Proforma was filled containing the basic information of the subject.

The candidates for the study group were selected based on their diagnosis (given by a psychiatrist) and scores on The Beck Depression Inventory (BDI) and The Hamilton Rating Scale for Depression (HAM-D).

The candidates for the control group were selected based on their score on The General Health Questionnaire-12.

TOOLS USED:

Information was collected through questionnaires and socio-demographic details were collected via pre-designed proforma for each individual that was chosen to be a part of the study, after obtaining an informed consent.

Socio-demographic proforma, especially designed for present study to obtain informed consent, collect the information regarding socio-demographic details, along with presenting complaints, past history of psychiatric illness and alcohol/drug abuse was used.

The Beck Depression Inventory (BDI), developed by Beck, et al., 1961 [175], is a 21- item, self-report rating inventory. It was administered to measures characteristic attitudes and symptoms of depression. It was used to measure the frequency and intensity of depressive symptoms. BDI

is known to have high internal consistency in both psychiatric and non-psychiatric samples, with its mean alpha coefficient being 0.86 for psychiatric patients[176]. BDI has shown good reliability with internal consistency being on the average higher than 0.75, high content validity, validity in differentiating between depressed and non-depressed subjects, sensitivity to change, and internal propagation [177].

The Hamilton Rating Scale for Depression abbreviated as HAM-D (Hamilton, M. (1960)), is a clinician administered instrument. It was administered to measure severity of depression in individuals. The internal consistency reliability was reported to be high and ranged from 0.91 to .94 and showed evidence for content, criterion-related, construct, and clinical efficacy [178].

Communication Styles Inventory (CSI), consisting of 96, items which has its roots in a lexical study on communication styles (De Vries, Bakker-Pieper, AltingSiberg, Van Gameren, Vlug, 2009) was administered to assess the communication styles of individuals. All the items were to be answered on a Likert-type scale ranging from 1 (completely disagree) to 4 (completely agree). Cronbach reliabilities of the CSI scales ranged from .82 to .88 [50]. The different domains of the questionnaire are named Expressiveness, Preciseness, Verbal Aggressiveness, Questioningness, Emotionality and Impression Manipulativeness. The different domains represent the following facets:

- Expressiveness – Talkativeness, conversational dominance, humor and informality.
- Preciseness – Structuredness, thoughtfulness, substantiveness and conciseness.
- Verbal Aggressiveness – Angriness, authoritarianism, derogatoriness and non-supportiveness.
- Questioningness – Unconventionality, philosophicalness, inquisitiveness and argumentativeness.

- Emotionality – Sentimentality, worrisomeness, tension and defensiveness
- Impression Manipulativeness – Ingratiation, charm, inscrutableness and concealingness.

The Silencing the Self Scale (STSS), by Dana Crowley Jack (1991), consisting of 31 items was administered. Internal consistency (alpha) for STSS ranges from 0.86 to 0.94, 'excellent' test-retest reliability[79]. The subscales of this scale are:

- Externalized self-perception – Reflects the degree to which one judges the self by external standards.
- Care as self-sacrifice – Degree to which one puts the needs of others before self.
- Silencing the self – Degree to which one inhibits self expression and action to avoid conflict, possible loss and retaliation from others.
- Divided self – Degree to which one presents an outer compliant self that does not express internal authentic thoughts and feelings.

The General Health Questionnaire - 12 (GHQ - 12), developed by Goldberg in 1970s was administered to the healthy control group to detect individuals who were at a risk of developing psychiatric disorders. The tool has demonstrated good internal consistency with Cronbach's alpha value of 0.93[179]. It has been divided into four subscales: somatic symptoms, anxiety/insomnia, social dysfunction and severe depression.

STATISTICAL ANALYSIS:

Data was described in terms of range; mean ±standard deviation (± SD), median, frequencies (number of cases) and relative frequencies (percentages) as appropriate. Comparison of quantitative variables between the study groups was done using Student t-test for independent samples for parametric. For comparing categorical data, Chi square ($\chi 2$) test was performed and exact test was used when the expected frequency is less than 5. A probability value (p value) less than 0.05 was considered statistically significant. A probability value (p value) less than 0.05 was

considered statistically significant. All statistical calculations was done using SPSS (Statistical Package for the Social Science) SPSS 21 version statistical program for Microsoft Windows.

OBSERVATIONS AND RESULTS

Table 1: Distribution of participants of the study group (participants with depression) in terms of gender (n=100)

GENDER	NO. OF PATIENTS	PERCENTAGE
Male	**50**	**50%**
Female	**50**	**50%**

The study included 50 males and 50 females diagnosed with either moderate or severe levels of depression.

Table 2: Distribution of participants of the control group (participants without depression) in terms of gender (n=100)

GENDER	NO. OF PATIENTS	PERCENTAGE
Male	**50**	**50%**
Female	**50**	**50%**

The study included 50 males and 50 females diagnosed without the diagnosis of depression.

Table 3: Descriptive statistics and difference between the mean age (years) of participants with depression and without depression

Overall	Depressed (n=100)		Non-Depressed (n=100)		t	p-value
	Mean	SD	Mean	SD		
Age	39.44	12.47	38.74	11.67	0.410	0.682

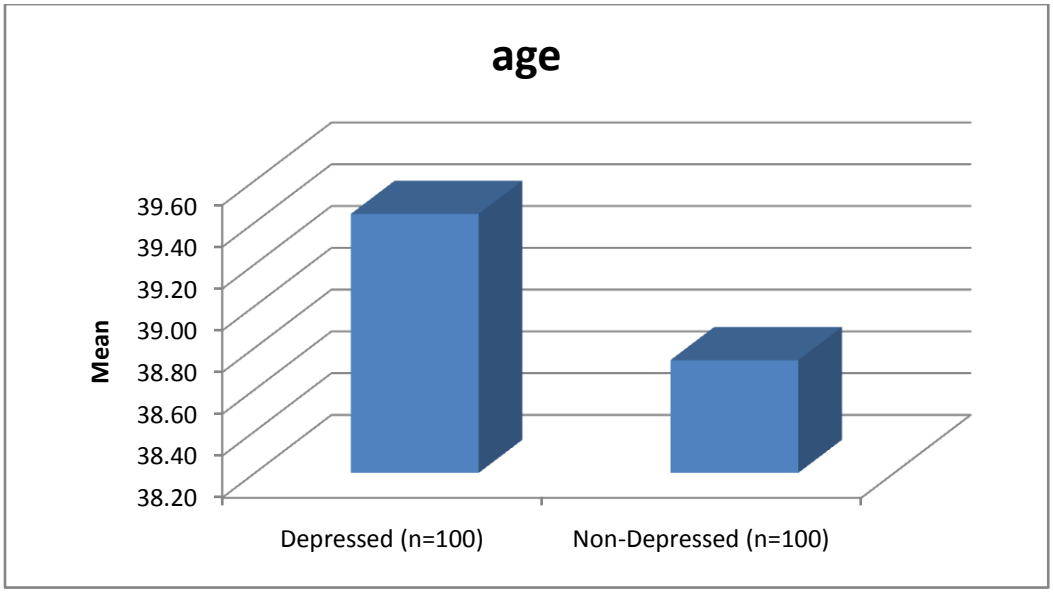

Figure 1: Descriptive statistics for participants with depression and without depression in terms of Age (years)

Table 3 and Figure 1 shows, the mean age of participants in the study group was 39.44 and the standard deviation was 12.47.

The mean age of participants in the control group was 38.74 and the standard deviation was 11.67.

There was no significant difference in the mean age of participants in study group and control group (t=0.410, p-value=0.682).

Table 4: Distribution of and relationship between participants with depression and without depression in terms of socio-economic status

		Depressed				Total	Chi-square value	p-value
		Depressed (n=100)		Non-Depressed (n=100)				
SES	L	1	1%	0	0%	1	3.398	0.334
	LM	69	69%	77	77%	146		
	UL	14	14%	14	14%	28		
	UM	16	16%	9	9%	25		
Total		100	100%	100	100%	200		

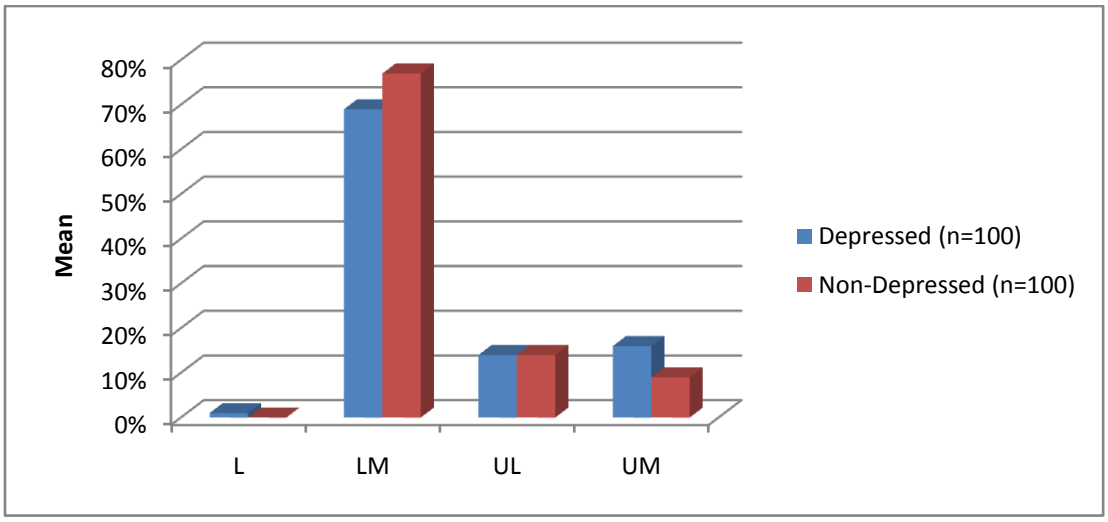

Figure 2: Distribution of and relationship between participants with depression and without depression in terms of socio-economic status

Table 4 and Figure 2 shows, the distribution of and relationship between participants according to SES in the study group for L, LM, UL and UM as 1%, 69 %, 14% and 16% for the study group and 0%, 777%, 14% and 9% for the control group respectively.

There was no significant difference in the mean SES of participants in study group and control group (chi square=3.398, p-value=0.334).

Table 5: Distribution of and relationship between males and females in terms of socio-economic status

Sex			Depressed		Total	Chi-square value	p-value
			Depressed (n=50)	Non-Depressed (n=50)			
Female	SES	LM	33	36	69	1.516	0.469
		UL	9	10	19		
		UM	8	4	12		
	Total		50	50	100		
Male	SES	L	1	0	1	2.128	0.546
		LM	36	41	77		
		UL	5	4	9		
		UM	8	5	13		
	Total		**50**	**50**	**100**		

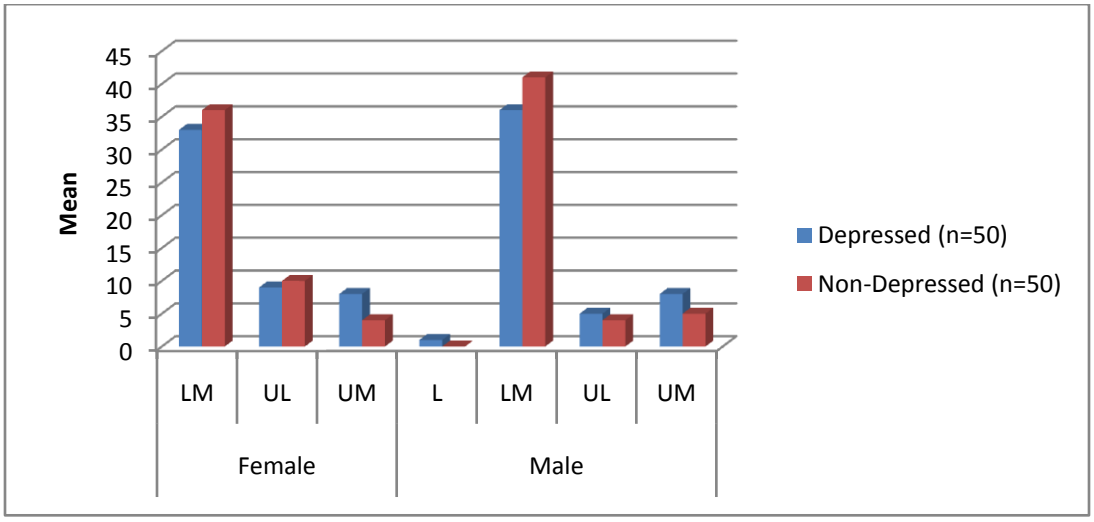

Figure 3: Distribution of and relationship between males and females in terms of socio-economic status

Table 5 and Figure 3 show the distribution of and relationship between males and females in terms of SES. The distribution of females in the

study group for LM, UL and UM was 33, 9 and 8 for the study group and 36, 10 and 4 for the control group respectively. The overall distribution of females in LM, UL and UM was 69, 19 and 12 respectively. The distribution of males in the study group for L, LM, UL and UM was 1, 36, 5 and 8 for the study group and 0, 41, 4 and 5 for the control group respectively. The overall distribution of males in L, LM, UL and UM was 1, 77, 9 and 13 respectively.

There was no significant difference in the mean SES of females in study group and control group (chi square=1.516, p-value=0.469). There was no significant difference in the mean SES of males in study group and control group (chi square=2.128, p-value=0.546).

Table 6: Descriptive statistics for BDI, HAM-D & GHQ for depressed and non-depressed participants.

Overall	Depressed (n=100)		Non-Depressed (n=100)	
	Mean	SD	Mean	SD
BDI	28.11	5.48	-	-
HAM-D	18.30	2.87	-	-
GHQ	-	-	8.87	2.95

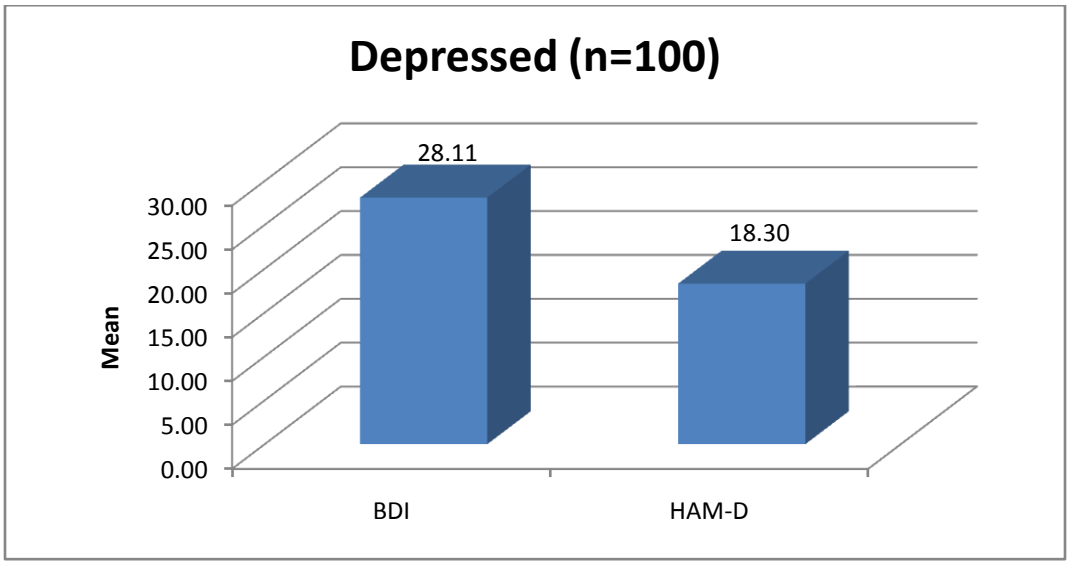

Figure 4: Descriptive statistics for BDI, HAM-D & GHQ for depressed and non-depressed participants.

Table 6 and Figure 4 show, the mean scores for BDI in depressed participants were 28.11 and standard deviation was 5.48.

The mean scores for HAM-D in depressed participants were 18.30 and standard deviation was 2.87.

The mean scores for GHQ in non-depressed participants were 8.87 and standard deviation was 2.95.

Table 7: Descriptive statistics for BDI, HAM-D & GHQ for depressed and non-depressed females.

Female	Depressed (n=50)		Non-Depressed (n=50)	
	Mean	SD	Mean	SD
BDI	28.98	5.34	-	-
HAM-D	18.48	2.94	-	-
GHQ	-	-	9.04	2.99

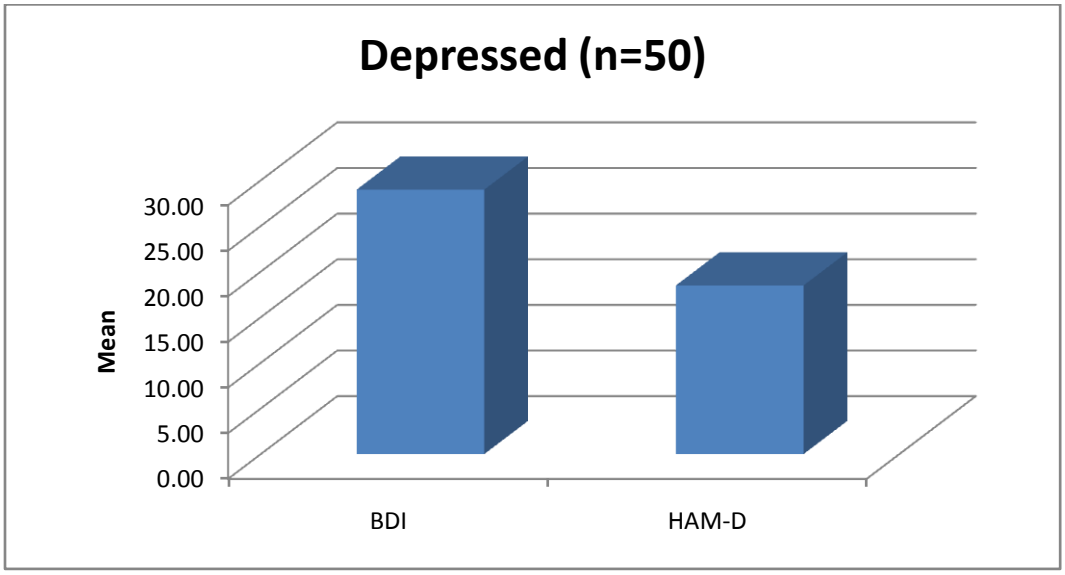

Figure 5: Descriptive statistics for BDI, HAM-D & GHQ for depressed and non-depressed participants.

Table 7 and Figure 5 show, the mean scores for females on BDI in depressed group were 28.98 and standard deviation was 5.34.

The mean scores for females on HAM-D in depressed group were 18.48 and standard deviation was 2.94.

The mean scores for females GHQ in non-depressed group were 9.04 and standard deviation was 2.99.

Table 8: Descriptive statistics for BDI, HAM-D & GHQ for depressed and non-depressed males.

Male	Depressed (n=50)		Non-Depressed (n=50)	
	Mean	SD	Mean	SD
BDI	27.24	5.53	-	-
HAM-D	18.12	2.81	-	-
GHQ	-	-	8.70	2.92

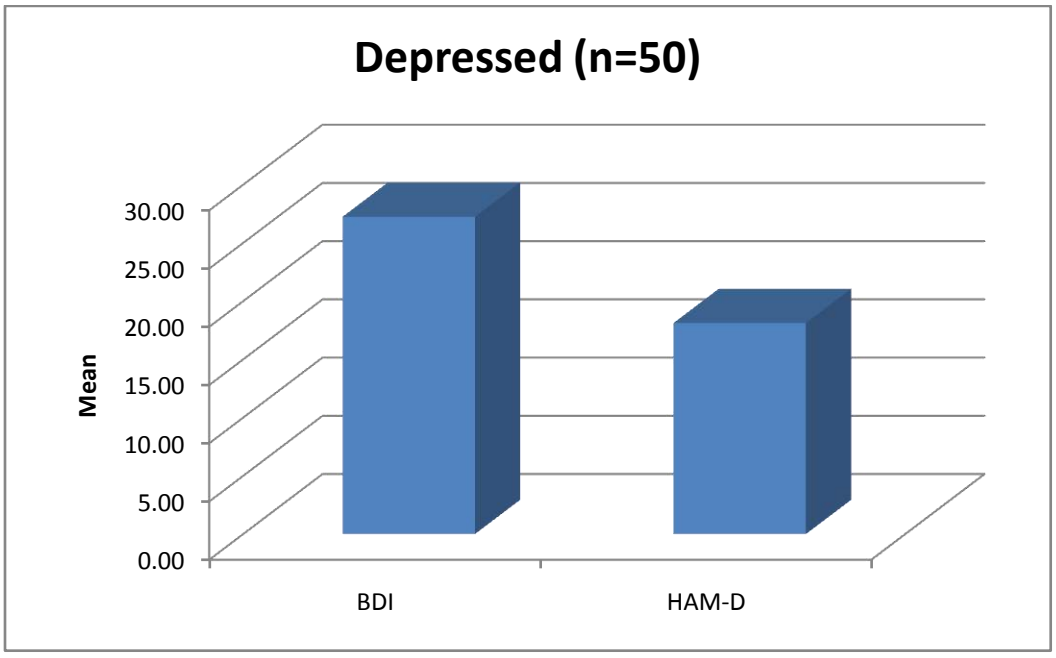

Figure 6: Descriptive statistics for BDI, HAM-D & GHQ for depressed and non-depressed males.

Table 8 and Figure 6 show, he mean scores for males on BDI in depressed group was 27.24 and standard deviation was 5.33.

The mean scores for males HAM-D in depressed group was 18.12 and standard deviation was 2.81.

The mean scores for males on GHQ in non-depressed group as 8.70 and standard deviation was 2.92.

Table 9: Comparison between silencing of self in depressed and non depressed participants.

Overall	Depressed (n=100)		Non-Depressed (n=100)		t	p-value
	Mean	SD	Mean	SD		
STSS	108.67	15.74	85.27	16.27	10.336	**0.000**
ESP	22.30	5.14	16.10	5.16	8.507	**0.000**
CSS	28.36	5.11	22.12	3.90	9.706	**0.000**
STS	31.23	5.89	26.14	6.03	6.040	**0.000**
DS	27.62	3.95	21.47	4.50	10.261	**0.000**

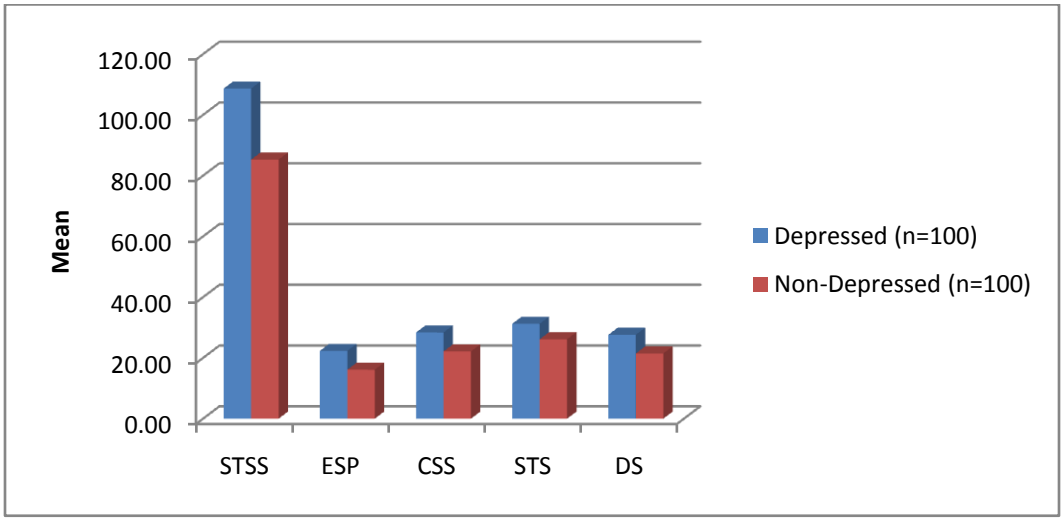

Figure 7: Comparison between silencing of self in depressed and non depressed participants.

Table 9 and Figure 7 show, the comparison between the scores of silencing of self in depressed and non-depressed participants. The mean of overall score was 108.67 and subscales of external self perception care as self sacrifice, silencing the self and divided self were 22.30, 28.36, 31.23 and 27.62 respectively in the depressed group. The standard deviation of overall score, subscales of external self perception, care as

self sacrifice, silencing the self and divided self was 15.74, 5.14, 5.11, 5.89 and 3.95 respectively in the depressed group.

The mean score of overall score was 85.27 and of subscales of external self perception, care as self sacrifice, silencing the self and divided self were 16.10, 22.12, 26.14 and 21.47 respectively in the non depressed group. The standard deviation of overall score, subscales of external self perception, care as self sacrifice, silencing the self and divided self was 16.27, 5.16, 3.90, 6.03 and 4.50 respectively in the non depressed group.
The mean scores for the depressed group were higher than the non depressed group and there was significant difference in the overall silencing the self scores (t=10.336, p-value=0.000), in external self perception (t=8.507, p-value=0.000), care as self sacrifice (t=9.706, p-value=0.000), silencing the self (t=6.040, p-value=0.000) and divided self (t=10.261, p-value=0.000).

Table 10: Comparison between silencing of self in depressed and non depressed females.

Female	Depressed (n=50)		Non-Depressed (n=50)		t	p-value
	Mean	SD	Mean	SD		
STSS	107.94	16.45	77.94	16.77	9.029	**0.000**
ESP	21.12	4.98	13.90	4.85	7.344	**0.000**
CSS	29.80	5.99	20.72	3.81	9.050	**0.000**
STS	30.34	6.27	22.84	5.95	6.135	**0.000**
DS	27.42	4.13	20.68	4.83	7.503	**0.000**

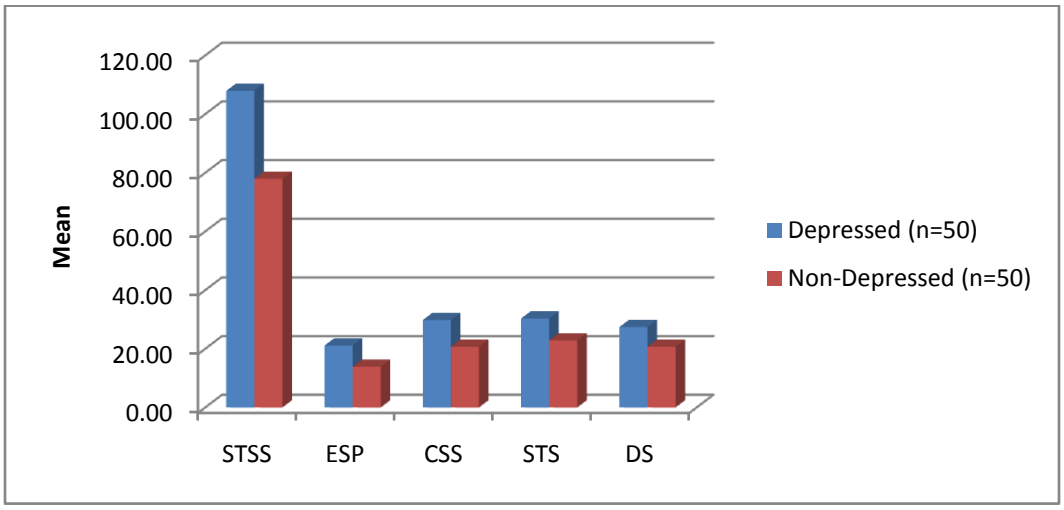

Figure 8: Comparison between silencing of self in depressed and non depressed females.

Table 10 and Figure 8 shows the comparison between the scores of silencing of self in depressed and non-depressed females. The mean score of overall score, subscales of external self perception, care as self sacrifice, silencing the self and divided self were 107.94, 21.12, 29.80, 30.34 and 27.42 respectively in the depressed group. The standard deviation of overall score, subscales of external self perception, care as

self sacrifice, silencing the self and divided self was 16.45, 4.98, 5.99, 6.27 and 4.13 respectively in the depressed group.

The mean score of overall score, subscales of external self perception, care as self sacrifice, silencing the self and divided self were 77.94, 13.90, 20.72, 22.84 and 20.68 respectively in the non depressed group. The standard deviation of overall score, subscales of external self perception, care as self sacrifice, silencing the self and divided self was 16.77, 4.85, 3.81, 5.95 and 4.83 respectively in the non depressed group.

The mean scores for the depressed group were higher than the non depressed group and there was significant difference in the overall silencing the self scores (t=9.029, p-value=0.000), in external self perception (t=7.344, p-value=0.000), care as self sacrifice (t=9.050, p-value=0.000), silencing the self (t=6.135, p-value=0.000) and divided self (t=7.503, p-value=0.000).

Table 11: Comparison between silencing of self in depressed and non depressed males.

Male	Depressed (n=50)		Non-Depressed (n=50)		t	p-value
	Mean	SD	Mean	SD		
STSS	109.40	15.12	92.60	12.01	6.152	**0.000**
ESP	23.48	5.08	18.30	4.52	5.385	**0.000**
CSS	26.92	3.56	23.52	3.51	4.814	**0.000**
STS	32.12	5.40	29.44	3.97	2.827	**0.006**
DS	27.82	3.80	22.26	4.05	7.075	**0.000**

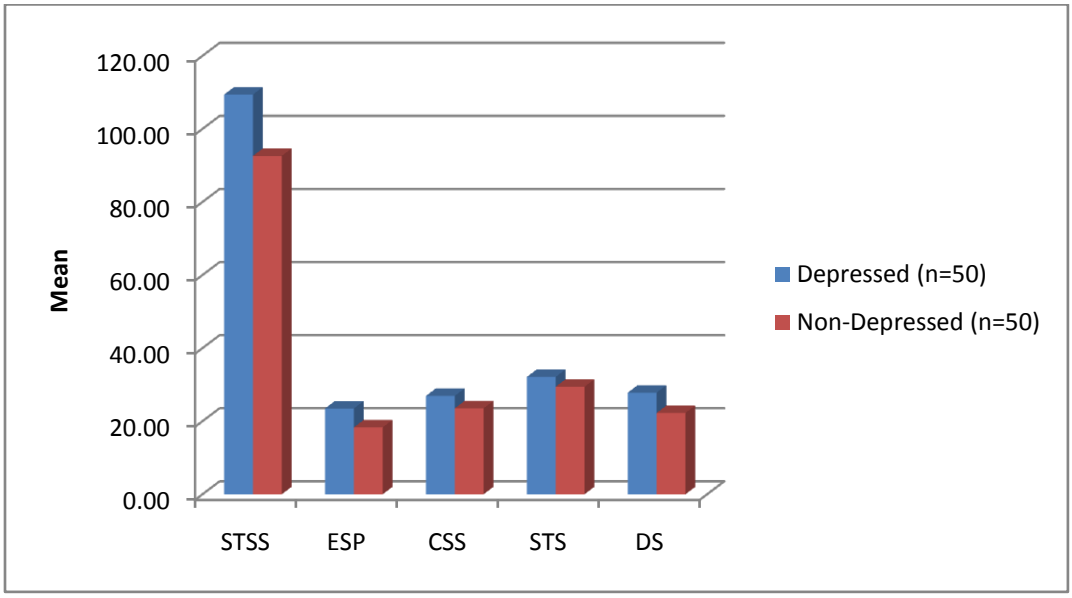

Figure 9: Comparison between silencing of self in depressed and non depressed males.

Table 11 and Figure 9 shows the comparison between the scores of silencing of self in depressed and non-depressed males. The mean score of overall score, subscales of external self perception, care as self sacrifice, silencing the self and divided self were 109.40, 23.48, 26.92, 32.12 and 27.82 respectively in the depressed group. The standard deviation of overall score, subscales of external self perception, care as

self sacrifice, silencing the self and divided self was 15.12, 5.08, 3.56, 5.40 and 3.80 respectively in the depressed group.

The mean score of overall score, subscales of external self perception, care as self sacrifice, silencing the self and divided self were 92.60, 18.30, 23.52, 29.44 and 22.26 respectively in the non depressed group. The standard deviation of overall score, subscales of external self perception, care as self sacrifice, silencing the self and divided self was 12.01, 4.52, 3.51, 3.97 and 4.05 respectively in the non depressed group.

The mean scores for the depressed group were higher than the non depressed group and there was significant difference in the overall silencing the self scores (t=6.152, p-value=0.000), in external self perception (t=5.385, p-value=0.000), care as self sacrifice (t=4.814, p-value=0.000), silencing the self (t=2.827, p-value=0.006) and divided self (t=7.075, p-value=0.000).

Table 12: Comparison between communication style in depressed and non depressed participants.

Overall	Depressed (n=100)		Non-Depressed (n=100)		t	p-value
	Mean	SD	Mean	SD		
EX	48.79	12.07	56.01	8.47	-4.896	**0.000**
PR	46.18	6.37	47.16	8.69	-0.910	0.364
VA	45.58	11.80	44.57	8.76	0.687	0.493
QU	47.63	7.17	44.18	7.64	3.292	**0.001**
EMO	51.40	8.63	44.28	9.78	5.458	**0.000**
IM	46.00	6.64	45.57	8.29	0.405	0.686

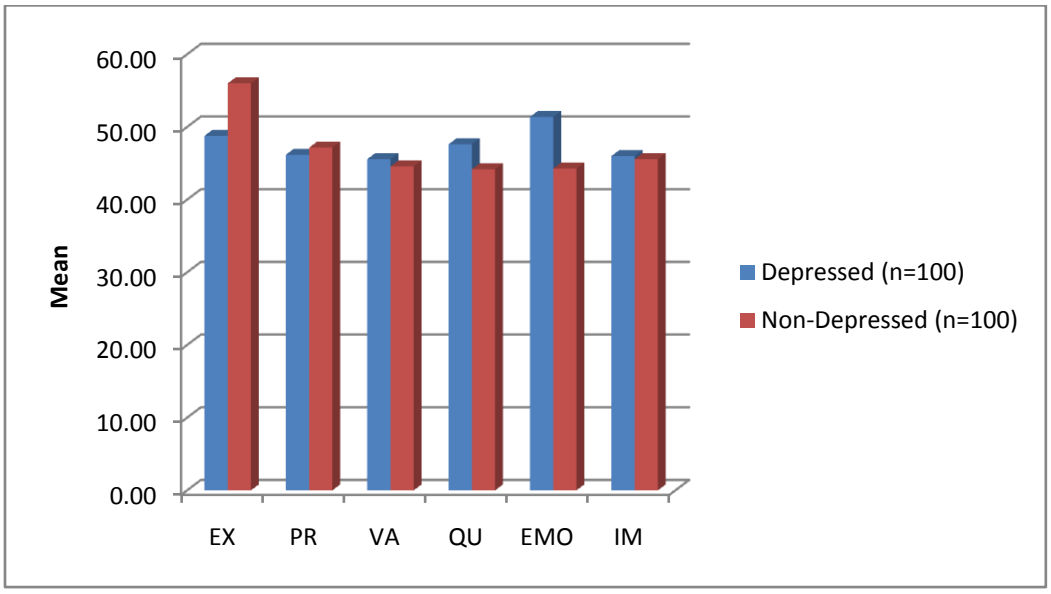

Figure 10: Comparison between communication style in depressed and non depressed participants.

Table 12 and Figure 10 shows the comparison between the scores of communication style in depressed and non-depressed group. The mean score of overall score, subscales of expressiveness, preciseness, verbal

aggressiveness, questionningness, emotionality and impression manipulativeness was 48.79, 46.18, 45.58, 47.63, 51.40 and 46.00 respectively in the depressed group. The standard deviation of expressiveness, preciseness, verbal aggressiveness, questionningness, emotionality and impression manipulativeness was 12.07, 6.37, 11.80, 7.17, 8.63 and 6.64 respectively in the depressed group.

The mean score of expressiveness, preciseness, verbal aggressiveness, questionningness, emotionality and impression manipulativeness was 56.01, 47.16, 44.57, 44.18, 44.28 and 45.57 respectively in the non depressed group. The standard deviation of expressiveness, preciseness, verbal aggressiveness, questionningness, emotionality and impression manipulativeness was 8.47, 8.69, 8.76, 7.64, 9.78 and 8.29 respectively in the non depressed group.

There was significant difference in the expressiveness (t= -4.896, p-value=0.000), questionningness (t=3.292, p-value=0.001) and emotionality (t= 5.458, p-value=0.000).

Table 13: Comparison between communication style in depressed and non depressed females.

Female	Depressed (n=50)		Non-Depressed (n=50)		t	p-value
	Mean	SD	Mean	SD		
EX	53.40	14.52	53.50	9.04	-0.041	0.967
PR	46.60	6.90	44.74	9.98	1.084	0.281
VA	41.90	13.14	42.08	9.34	-0.079	0.937
QU	48.08	7.60	42.88	9.14	3.093	**0.003**
EMO	56.56	7.42	46.68	11.27	5.178	**0.000**
IM	45.74	7.80	49.84	7.15	-2.740	**0.007**

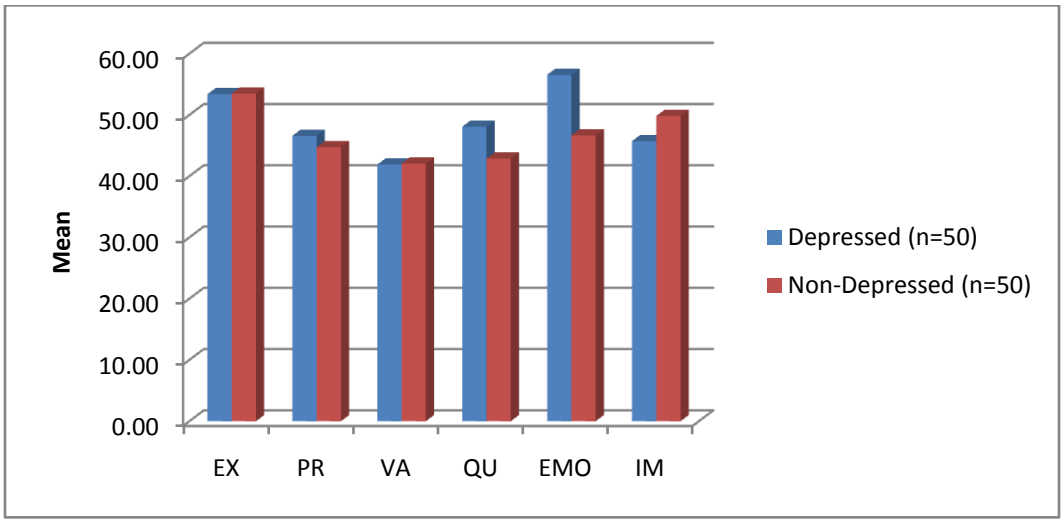

Figure 11: Comparison between communication style in depressed and non depressed females.

Table 13 and Figure 11 show the comparison between the scores of communication style in depressed and non-depressed females. The mean score of subscales of expressiveness, preciseness, verbal aggressiveness, questionningness, emotionality and impression

manipulativeness was 53.40, 46.60, 41.90, 48.08, 56.56 and 45.74 respectively in the depressed group. The standard deviation of expressiveness, preciseness, verbal aggressiveness, questionningness, emotionality and impression manipulativeness was 14.52, 6.90, 13.14, 7.60, 7.42 and 7.80 respectively in the depressed group.

The mean score of expressiveness, preciseness, verbal aggressiveness, questionningness, emotionality and impression manipulativeness was 53.50, 44.74, 42.08, 42.88, 46.68 and 49.84 respectively in the non depressed group. The standard deviation of expressiveness, preciseness, verbal aggressiveness, questionningness, emotionality and impression manipulativeness was 9.04, 9.98, 9.34, 9.14, 11.27 and 7.15 respectively in the non depressed group of females.

There was significant difference in the questionningness (t=3.093, p-value=0.003), emotionality (t= 5.178, p-value=0.000) and impression manipulativeness (t= -2.740, p-value=0.007).

Table 14: Comparison between communication style in depressed and non depressed males.

Male	Depressed (n=50)		Non-Depressed (n=50)		t	p-value
	Mean	SD	Mean	SD		
EX	44.18	6.35	58.52	7.10	-10.640	**0.000**
PR	45.76	5.83	49.58	6.40	-3.120	**0.002**
VA	49.26	9.00	47.06	7.41	1.334	0.185
QU	47.18	6.76	45.48	5.57	1.373	0.173
EMO	46.24	6.41	41.88	7.38	3.152	**0.002**
IM	46.26	5.31	41.30	7.10	3.955	**0.000**

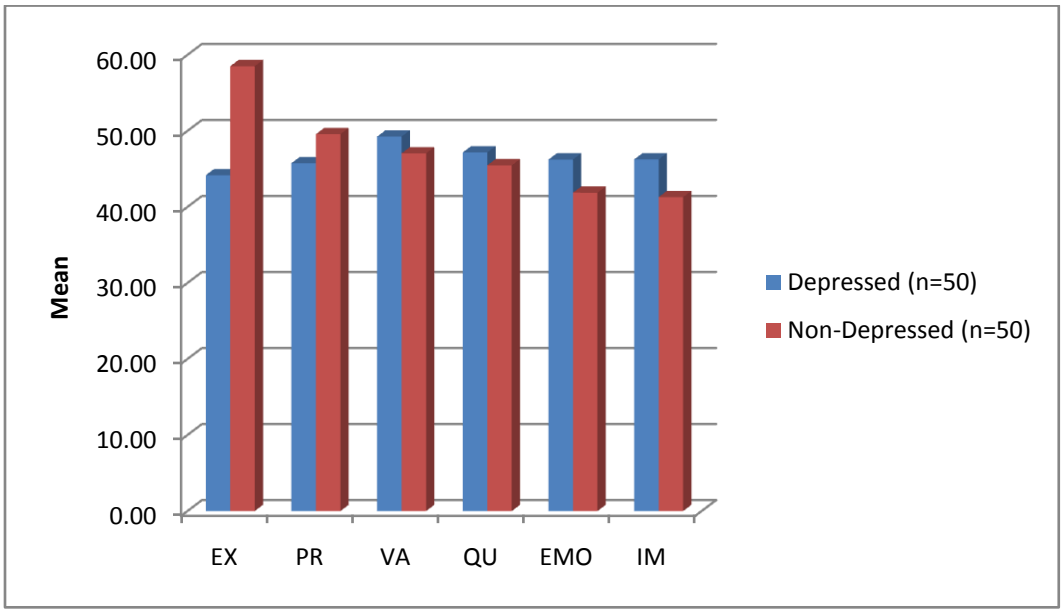

Figure 12: Comparison between communication style in depressed and non depressed males.

Table 14 and Figure 12 show the comparison between the scores of communication style in depressed and non-depressed males. The mean score of subscales of expressiveness, preciseness, verbal

aggressiveness, questionningness, emotionality and impression manipulativeness was 44.18, 45.76, 49.26, 47.18, 46.24 and 46.26 respectively in the depressed group. The standard deviation of expressiveness, preciseness, verbal aggressiveness, questionningness, emotionality and impression manipulativeness was 6.35, 5.83, 9.00, 6.76, 6.41 and 5.31 respectively in the depressed group.

The mean score of expressiveness, preciseness, verbal aggressiveness, questionningness, emotionality and impression manipulativeness was 58.52, 49.58, 47.06, 45.48, 41.88 and 41.30 respectively in the non depressed group. The standard deviation of expressiveness, preciseness, verbal aggressiveness, questionningness, emotionality and impression manipulativeness was 7.10, 6.40, 7.41, 5.57, 7.38 and 7.10 respectively in the non depressed group of males.

There was significant difference in expressiveness (t= -10.640, p-value=0.000), preciseness (t= -3.120, p-value=0.002), emotionality (t= 3.152, p-value=0.002) and impression manipulativeness questionningness (t=3.955, p-value=0.000).

DISCUSSION

The present study intended to compare the communication styles and silencing of self in participants with and without depression. In order to adjudicate the aforesaid intention, the researcher decided on four objectives – to study the gender differences between communication styles in individuals with and without depression**,** to study the gender differences between silencing of self in individuals with and without depression, to study the relationship between communication styles in individuals with and without depression and to study the relationship between silencing of self in individuals with and without depression. To carry through with the objectives of the study the initial computations were done by the means of mean and standard deviation, chi square and t-test. The study group comprised of individuals diagnosed with depression of either moderate or severe category, while the control group comprised of individuals who had no diagnosis of depression and any other psychiatric comorbidity. The distribution of participants in both the study group and control group was of 50% males and 50% females. At the outset the descriptive statistics and the difference between the mean age of participants with and without depression was calculated which yielded non-significant results, indicating that the participants were from the same population in terms of age. The distribution and difference of depressed and non-depressed participants in terms of socio-economic status came out to be non-significant. This implies that there was no significant difference between the sample subjects with respect to the socio-economic status and they came from the same population. The distribution of males and females in terms of socio-economic status also yielded non-significant results implying that they represented the same population.

To study the gender differences between communication styles in individuals with and without depression.

The existing study purported to analyze the gender differences that prevail in communication styles adopted by individuals who have depression and those who do not. Communication is the most important aspect of being a human and of living in a society. It is widely accepted that there are difference in the manner in which men and women communicate. The conventional wisdom leads us to believe that emotions are believed to be experienced and expressed in different intensities and manners in both men and women[180-182]. The stress and sentiment is an all important facet of humans and both are thought to play huge roles in a person's life. The likelihood of having depression is increased in individuals with elevated levels of perceived stress [183,184]. The gender roles are such that a girl's sentiments are nurtured more carefully than boy's and girls are expected to have superior interpersonal skills and better ability tp communicate non-verbally[185-187]. Expressiveness as a communication style endorses humor, informality and conversational dominance and makes up a talkative individual. Preciseness as a communication styles precludes thoughtfulness and structuredness at its very core. The results of the present found that depressed females adopted the communication style of emotionality and questionningness while depressed males adopted the one of emotionality and impression manipulativeness in comparison with non-depressed females who adopted the communication style of impression manipulativeness and non-depressed males who adopted the one of expressiveness and preciseness. The findings are in keeping with the existing literature that purports that women scored significantly higher on Emotionality and somewhat lower on Verbal Aggressiveness, Preciseness[188]. The present findings are in keeping with the finding that observed that women tend to change their statements into questions[140,141]. The findings are supported by previous literature portraying that women use more emotional ways of communication[135].

The results for males on communication styles yielded positive findings on the subscales of expressiveness, preciseness, emotionality and impression manipulativeness. The depressed group was higher on emotionality and impression manipulativeness. The non depressed group was higher on expressiveness and preciseness as compared to their depressed counterparts. The researcher did not come across literature catering to the enlightenment on the communication styles more prominently used by men. However, previous research has shown that men and women use language differently, supporting gender gaps in communication styles[134]. They continue to demonstrate that when they speak to people, women use signals of courtesy and they show respect by listening and recalling what has been said. In terms of communication style, women appear to be more verbal, hesitant, respectful, social, while men are more assertive and dominant on average[189].

To study the gender differences between silencing of self in individuals with and without depression.

The existing study purported to decipher the gender differences between silencing of self in individuals with and without depression. The existing literature exhibits contrasting findings in terms of gender differences in silencing of self. The act of self-silencing stems from the motivation to maintain and sustain relationships with others and it lies at the core of women's self concept. The silencing the self theory built upon a longitudinal study of clinically depressed women, their experiences and understanding of the same, purports that 'I' (i.e., voice of self) and the 'Over-Eye' (i.e. cultural and moralistic voice of the society prescribing 'shoulds') result in inner arguments and a divided self, and therefore silencing of self[78].

The results of the present study showed that both the genders yielded significant results for silencing of self but males had higher scores on silencing of self as compared to females. The overall silencing the self

score was higher for males than females. Men also scored higher on the subscales of externalized self perception, silencing the self and divided self, but the difference on the divided self subscale was very small. The previous studies examining self-silencing among adolescents and adults of both genders report that males score higher than females[171,190]; whereas some other studies have found no significant differences in gender[191]. The sex differential could be due to the reason that men and women interpret self-silencing in different ways[171,190]. Men prefer to withdraw during situations of conflicts [192,193] and ensuing self-silencing may occur due to the desire to avoid intimacy, conflict, or possible situations that limit independence [194,195] . Researchers also identify the phenomenon of 'stonewalling', where men withdraw from situations of conflict by silencing themselves or walking away among various other tactics[192]. It is likely that males and females can interpret and experience silencing the self differently, thereby having a different effect depending on the sex of the individual engaged in the action. Men may compliment themselves on putting the needs of their female partners above their own, while women may feel that placing the needs of their partners ahead of their own results in a "loss of self" because of social pressures[171].

To study the relationship between communication styles in individuals with and without depression.

The intent of this study was to probe into the relationship between communication styles in individuals with and without depression. The effects of mood on the way in which people communicate are well known. One of the features that even a layman would note in a depressed individual is the difference in the manner in which they communicate and express their feelings. Many a times, it is pointed that one is not expressive enough and does not communicate their feelings and emotions. The present study brought evidence for this mundane dialogue as the results noted that depressed individuals were low on

expressiveness, a communication style explained as non verbal manifestation of extraversion. Expressive individuals are gabby, use humor and are usually informal in their manners. Preciseness as a communication style, at its very heart necessitates thoughtfulness and structuredness. Being expressive and precise is usually lacking in clinically depressed subjects. The results showed that depressed subjects demonstrated the communication styles of questionningness and emotionality, while the non-depressed subjects demonstrated expressiveness. The finding that depressed subjects scored low on expressiveness, is supported primarily by Freud's tenet that postulates depression to be caused by aggression that is turned inwards. The preciseness, verbal aggressiveness and impression manipulativeness did not yield any significant results. The researcher could not retrieve any research that would enlighten about the communication styles measured by communication styles inventory and their role in depression. However, researches on distressed couples who have a depressed partner have been found generally to interact more negatively and less positively[127,128,130]. Further there is dearth of literature comparing the communication style used by depressed individuals and non depressed ones.

To study the relationship between silencing of self in individuals with and without depression.

The study aimed to investigate the relationship between silencing of self in individuals with and without depression. Silencing the self theory describes how the silenced voices lead to a loss of self, which further adds to the shame, desperation and anger when one feels entrapped as a result of conflicts between the 'I' and the 'Over-Eye'. The women's inner arguments about the way they should act resulting in divided self, where inwardly they experience anger and on the outside present a pleasing and compliant self holding up to the cultural demands bring about depression

in them[78]. The results of the present investigation show that individuals with depression show higher silencing of self. The overall score on silencing of self and subscales yielded significant results. The results depicted that participants with depression showed higher silencing of self as compared to their non depressed counterparts. The present findings are in line with existing literature where association between self-silencing and depressive symptoms for both males and females was reported[168,171]. But the mentioned study also reported of methodological issues (e.g., sample population) that was purported to possibly explain the absence and/or presence of association between self-silencing and depressive symptoms, particularly among males. However, the findings are consistent with previous ones, although Jack's [65] theory, addressed only females, men too report of endorsing self-silencing behaviors in intimate relationships and many a time more than women[172,190]. While research has shown that the Silencing the Self Scale is internally consistent and is linked to depression and other variables that are potentially important, there has been little empirical evidence for the hypothesis that women participate in more silencing behaviors than men[168]. Men engaged in long-term relationships have also been found to engage in more self-silencing than their female partners.Research carried out on college communities has shown that men adopt self-silencing as much as women do[79,169]. Furthermore, research [165,172] supports that men score higher on the Silencing the Self Scale in their college samples than women.The present study observed that men scored higher on the subscales of externalized self perception and silencing the self, however the difference between the values of mean scores was small. A previous study [196] measuring the predictive utility of silencing the self scale and its subscales found that the two STSS subscales namely – Externalized Self-Perception and Silencing the Self, anticipated depression severity and implied that women in intimate relationships, who were at risk for depression were more likely to subdue anger, judge themselves by

external standards, and suppress their words and actions in order to avoid conflicts. Although the present study have found significant differences supporting the presence of silencing of self in males, the significant results on the aforementioned subscales reveals their accountability for depressive symptomatology. The results from the present study support Jack's [79] theory and points at anger suppression along with the facets of silencing the self and externalized self perception[196] i.e., judging the self as per external standards and concealing one's true self from others to be predictors of elevated depressive symptoms.

LIMITATIONS

The current study has certain limitations. The foremost being the use of purposive sampling. Reliance on self-report measures also delimits the study. A larger sample size for the study would have been better, for better generalizability of the findings.

SUMMARY AND CONCLUSION

The current research work was an effort to study the difference between communication styles and silencing of self in individuals with and without depression. Overall, significant results were found for afore stated objectives of the study. Communication style prominently used by depressed subjects was questionningness and emotionality while non-depressed subjects scored significantly higher on expressiveness. Females with depression yielded significant results on questionningness and emotionality while males on impression manipulativeness and emotionality. The non-depressed females were found to portray higher impression manipulativeness and males on expressiveness and preciseness. For silencing of self, the overall scores depict significantly higher silencing of self in males. In addition, males were reported to exhibit more externalized self perception, silencing the self and divided self, while females exhibited more care as self sacrifice. The findings on communication styles call for a much more elaborate analysis, as there is paucity of literature to gauge the general communication styles in individuals with and without depression. The findings on silencing the self are in line with existing literature, however the manner and extent to which it is done in males and females has contrasting findings. Since, silencing the self has been constituted to play a role in depression, it is imperative that these findings be generalized in Indian context.

FUTURE DIRECTIONS

In view of the findings and limitations, various future directions can be thought of. Firstly, assessing pre-morbid personalities of the depressed subjects can prove useful. Secondly, the use therapeutic interventions and regular assessments to gauge for changes could help to draw better inferences. Additionally, a longitudinal study design to probe into these variables would give useful insights.

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KEY TO MASTER CHART

Gender

1.1 – Depressed females

1.2 – Non-depressed females

2.1 – Depressed males

2.2 – Non-depressed males

SES

L Lower

LM Lower Middle

UL Upper Lower

UM Upper Middle

Scales

BDI Beck Depression Inventory

HAM-D Hamilton Rating Scale for Depression

CSI Communication Styles Inventory

STSS Silencing The Self Scale

GHQ General Health Questionnaire

EX Expressiveness

PR Preciseness

VA Verbal Aggressiveness

QU Questioningness

EMO Emotionality

IM Impression Manipulativeness

ESP Externalized self-perception

CSS Care as self-sacrifice

STS Silencing the self

DS Divided self

SES Socio Economic Status

S. NO.	Gender	Initials	MRD	Age	SES	BDI	HAM-D	GHQ	STSS	ESP	CSS	STS	DS	CSI	EX	PR	VA	QU	EMO	IM
1	1.1	BK	745498	66	LM	28	17	-	115	25	32	28	30	-	24	42	19	37	51	36
2	1.1	BB	61955	22	LM	24	14	-	105	28	29	21	27	-	50	43	45	49	57	43
3	1.1	HK	950490	44	LM	36	27	-	111	19	31	28	33	-	53	46	54	48	60	42
4	1.1	BK	745496	65	LM	24	21	-	106	23	29	24	30	-	24	42	20	37	51	37
5	1.1	RK	893014	23	LM	23	15	-	98	19	27	31	21	-	51	38	41	50	49	35
6	1.1	SR	38851	37	LM	46	29	-	74	15	21	17	21	-	62	43	41	53	66	55
7	1.1	M	846344	22	LM	28	15	-	121	20	32	39	30	-	25	44	23	55	63	51
8	1.1	SK	831940	40	LM	28	18	-	112	21	29	32	30	-	63	37	17	46	57	45
9	1.1	S	599811	41	LM	25	20	-	123	14	40	38	31	-	51	40	40	38	60	49
10	1.1	RK	661569	40	LM	32	18	-	85	11	21	30	23	-	68	38	42	45	50	38
11	1.1	PK	941735	39	LM	33	16	-	122	22	33	35	32	-	67	45	52	52	56	40
12	1.1	AA	900039	24	UL	17	16	-	102	18	38	20	26	-	71	45	52	61	64	36
13	1.1	LK	938742	25	UL	21	21	-	111	24	26	32	29	-	27	40	18	60	57	41
14	1.1	BK	956959	26	UL	26	16	-	98	19	27	31	21	-	52	38	55	39	51	41
15	1.1	A	1027599	25	UL	25	18	-	112	21	29	31	31	-	70	68	43	47	55	55
16	1.1	M	868842	37	UL	25	20	-	115	22	38	26	29	-	66	45	66	58	60	41
17	1.1	J	906653	38	UL	32	21	-	86	15	40	38	31	-	65	41	38	49	57	52
18	1.1	JK	223330	26	LM	27	19	-	138	24	40	41	32	-	52	48	51	39	35	40
19	1.1	MK	114919	24	LM	29	19	-	104	28	28	21	27	-	28	39	70	45	60	41
20	1.1	PK	699028	23	LM	27	19	-	85	11	21	30	23	-	68	50	56	50	45	46
21	1.1	M	868842	24	LM	25	15	-	107	28	29	22	28	-	68	62	19	60	52	45
22	1.1	JK	874401	35	UM	32	15	-	91	17	25	28	21	-	35	40	44	55	39	45
23	1.1	RK	192077	36	LM	23	20	-	95	18	26	29	22	-	52	43	33	48	61	51
24	1.1	BK	832586	36	LM	34	17	-	113	21	30	32	30	-	55	41	53	53	57	49
25	1.1	GK	989466	37	LM	26	17	-	144	29	41	42	32	-	62	37	59	35	57	56
26	1.1	SK	1003611	42	UL	29	21	-	111	24	26	32	29	-	52	49	20	40	56	43
27	1.1	SR	370011	37	LM	32	21	-	105	21	29	28	27	-	30	56	45	44	67	34
28	1.1	SK	270001	40	LM	32	18	-	105	28	27	21	29	-	36	58	20	39	38	40
29	1.1	SP	460023	40	LM	36	18	-	86	12	21	30	23	-	52	46	37	37	62	56
30	1.1	E	981640	36	LM	38	15	-	114	21	30	32	31	-	29	44	54	37	53	59
31	1.1	SK	938933	31	UM	32	18	-	144	29	42	41	32	-	49	52	49	59	60	54
32	1.1	AK	907035	26	UL	31	19	-	105	21	29	28	27	-	53	43	44	54	54	59
33	1.1	GK	918506	26	UM	25	15	-	114	22	37	26	29	-	42	50	37	61	58	49
34	1.1	JK	625010	38	UM	25	20	-	97	19	27	30	21	-	56	50	54	52	68	42
35	1.1	SK	425388	34	LM	35	20	-	101	27	26	20	28	-	63	46	32	38	58	37
36	1.1	N	929378	33	LM	26	21	-	111	24	26	32	29	-	62	48	46	41	52	46
37	1.1	M	856886	26	LM	24	15	-	98	20	27	30	21	-	62	49	36	56	69	35
38	1.1	GK	836848	25	LM	32	20	-	132	21	41	41	29	-	44	55	50	39	55	33
39	1.1	SK	975649	34	LM	35	16	-	77	12	19	25	21	-	68	48	53	58	71	49
40	1.1	PK	124370	24	UM	33	21	-	135	24	38	41	32	-	72	57	55	45	57	61
41	1.1	SK	897103	28	UM	26	20	-	135	25	37	41	32	-	70	60	47	49	70	37
42	1.1	KK	849094	20	UM	24	17	-	84	11	21	29	23	-	56	45	34	48	59	42
43	1.1	M	875415	42	UM	24	21	-	107	28	27	22	30	-	38	47	36	55	58	46
44	1.1	MK	945246	39	LM	30	15	-	91	17	25	28	21	-	63	46	29	47	58	52
45	1.1	RK	938741	41	LM	29	18	-	111	24	26	32	29	-	52	52	29	47	56	56
46	1.1	S	810706	45	LM	31	16	-	120	26	30	33	31	-	66	50	48	42	59	38
47	1.1	SK	850216	49	LM	22	20	-	130	27	33	37	33	-	61	55	50	55	48	54
48	1.1	SK	910013	47	UL	36	16	-	99	20	27	30	22	-	68	43	55	52	57	49
49	1.1	NK	875940	41	LM	28	19	-	114	21	30	32	31	-	75	48	36	43	55	44
50	1.1	SK	773388	42	LM	38	21	-	98	20	27	30	21	-	42	38	48	57	60	62
51	1.2	MK	-	32	LM	-	-	12	80	10	20	28	22	-	41	41	25	44	58	36
52	1.2	YG	-	37	LM	-	-	12	77	12	19	25	21	-	45	42	37	72	57	39
53	1.2	RK	-	40	LM	-	-	11	115	21	30	32	32	-	55	28	29	46	55	45
54	1.2	AK	-	40	LM	-	-	10	59	9	20	16	14	-	56	35	36	46	45	45
55	1.2	AS	-	36	LM	-	-	13	93	18	25	28	22	-	59	42	46	42	36	49
56	1.2	AS	-	31	UL	-	-	10	77	12	19	25	21	-	45	39	28	41	62	61
57	1.2	S	-	25	UL	-	-	5	69	11	22	19	17	-	59	39	36	40	42	53
58	1.2	S	-	34	UL	-	-	11	75	12	18	24	21	-	42	42	19	39	39	56
59	1.2	SS	-	24	UM	-	-	4	72	13	20	19	20	-	77	36	51	47	37	63
60	1.2	NS	-	28	LM	-	-	11	88	12	22	31	23	-	59	57	45	47	41	37
61	1.2	BS	-	20	LM	-	-	3	58	9	19	16	14	-	51	60	49	38	46	44
62	1.2	KS	-	42	UL	-	-	8	96	20	25	30	21	-	49	43	50	48	36	50
63	1.2	CS	-	39	LM	-	-	12	74	12	18	23	21	-	49	42	47	45	35	49
64	1.2	ES	-	41	LM	-	-	9	69	10	15	24	20	-	53	37	51	44	49	51
65	1.2	AS	-	45	UM	-	-	5	110	24	26	32	28	-	75	42	38	39	64	46
66	1.2	AA	-	24	UL	-	-	11	65	11	20	18	16	-	57	37	51	36	64	62
67	1.2	LK	-	25	UL	-	-	11	63	12	18	17	16	-	51	46	57	36	46	51
68	1.2	BK	-	26	LM	-	-	12	95	20	24	30	21	-	50	40	48	31	54	51

S. NO.	Gender	Initials	MRD	Age	SES	BDI	HAM-D	GHQ	STSS	ESP	CSS	STS	DS	CSI	EX	PR	VA	QU	EMO	IM
69	1.2	A	-	25	LM	-	-	10	88	12	22	31	23	-	45	36	39	70	51	38
70	1.2	M	-	37	UM	-	-	11	73	12	18	22	21	-	36	41	52	52	47	49
71	1.2	J	-	40	LM	-	-	10	60	10	20	16	14	-	48	33	63	51	56	61
72	1.2	JK	-	41	LM	-	-	8	63	12	18	17	16	-	41	44	31	40	52	43
73	1.2	MK	-	36	LM	-	-	6	63	12	17	18	16	-	56	33	63	49	48	51
74	1.2	PK	-	26	LM	-	-	9	81	11	20	28	22	-	59	45	36	40	48	59
75	1.2	M	-	38	LM	-	-	2	62	12	18	16	16	-	70	52	45	39	4	47
76	1.2	JK	-	34	LM	-	-	7	105	27	26	22	30	-	57	55	43	35	47	51
77	1.2	RK	-	26	LM	-	-	10	84	12	21	28	23	-	60	47	39	35	47	52
78	1.2	BK	-	35	LM	-	-	9	65	12	19	18	16	-	51	47	44	25	36	48
79	1.2	GK	-	20	UM	-	-	11	96	20	24	30	22	-	51	45	44	40	38	45
80	1.2	SD	-	21	UL	-	-	5	45	8	12	12	13	-	53	39	40	39	49	54
81	1.2	AD	-	23	LM	-	-	10	43	8	12	10	13	-	46	38	46	45	37	48
82	1.2	MB	-	25	UL	-	-	12	51	10	15	12	14	-	39	50	42	48	31	55
83	1.2	AS	-	43	UL	-	-	6	62	12	17	17	16	-	48	35	18	36	45	39
84	1.2	HK	-	40	UL	-	-	10	111	26	24	29	32	-	52	75	47	49	70	48
85	1.2	MM	-	41	LM	-	-	10	97	20	25	30	22	-	52	50	47	47	39	57
86	1.2	PK	-	39	LM	-	-	12	63	12	18	17	16	-	61	50	42	35	52	56
87	1.2	K	-	34	LM	-	-	5	65	12	19	17	17	-	59	46	39	36	67	42
88	1.2	RB	-	35	LM	-	-	11	97	20	25	30	22	-	52	48	51	48	48	59
89	1.2	S	-	26	LM	-	-	6	86	12	21	28	25	-	71	57	56	39	45	57
90	1.2	R	-	54	LM	-	-	1	75	12	20	22	21	-	48	37	40	49	35	60
91	1.2	GB	-	25	LM	-	-	12	74	12	19	22	21	-	48	56	40	40	44	53
92	1.2	NS	-	23	LM	-	-	5	71	12	18	20	21	-	70	69	42	42	47	55
93	1.2	MR	-	21	LM	-	-	10	100	26	24	28	32	-	49	40	36	38	31	60
94	1.2	SB	-	25	LM	-	-	11	75	12	20	22	21	-	38	56	38	29	68	40
95	1.2	ND	-	64	LM	-	-	11	84	12	28	21	23	-	63	71	42	68	52	49
96	1.2	ID	-	60	LM	-	-	9	84	12	21	23	28	-	52	40	40	51	43	41
97	1.2	JB	-	35	LM	-	-	8	84	12	21	28	23	-	59	32	32	37	48	51
98	1.2	NK	-	32	LM	-	-	11	98	20	27	30	21	-	58	36	36	31	48	39
99	1.2	MC	-	41	LM	-	-	12	80	12	26	19	23	-	55	39	44	40	50	50
100	1.2	SM	-	45	LM	-	-	12	77	13	21	22	21	-	55	47	44	40	45	47
101	1.2	JS	-	25	LM	-	-	12	99	26	24	28	27	-	65	49	47	50	52	48
102	2.1	GK	36384	36	LM	29	18	-	78	14	21	22	21	-	36	35	34	40	37	45
103	2.1	PS	982546	42	UM	39	21	-	124	26	30	37	31	-	54	44	43	49	44	45
104	2.1	KS	979066	20	LM	21	17	-	94	20	25	29	20	-	49	47	64	52	52	45
105	2.1	SS	1004017	52	LM	22	20	-	73	12	18	22	21	-	39	48	48	40	58	40
106	2.1	SS	411489	43	LM	25	17	-	107	27	26	24	30	-	33	48	44	45	44	38
107	2.1	BS	951170	47	LM	23	17	-	115	21	30	32	32	-	38	45	34	39	38	44
108	2.1	KS	996828	60	LM	34	21	-	78	14	21	22	21	-	38	43	35	40	38	46
109	2.1	DB	1002836	49	UM	29	15	-	101	26	24	29	32	-	48	48	60	50	45	45
110	2.1	R	22295	33	LM	23	17	-	109	27	27	25	30	-	40	46	52	50	45	46
111	2.1	HS	905567	35	LM	19	14	-	89	12	22	30	25	-	41	47	49	41	40	39
112	2.1	SK	37757	57	LM	13	23	-	96	19	25	30	22	-	34	50	47	42	44	35
113	2.1	KS	996828	60	LM	31	26	-	126	26	30	40	30	-	39	36	39	40	45	42
114	2.1	MK	1001915	66	UM	29	15	-	123	25	30	37	31	-	37	36	35	41	50	40
115	2.1	YG	1007149	48	UL	32	18	-	72	12	18	21	21	-	49	47	64	52	52	45
116	2.1	RK	834241	46	UL	22	15	-	108	28	25	26	29	-	39	48	48	40	58	40
117	2.1	AK	180768	58	LM	33	18	-	117	23	32	32	30	-	33	48	44	45	44	38
118	2.1	AS	1008295	34	LM	25	15	-	119	25	31	33	30	-	40	40	49	50	49	50
119	2.1	AS	881144	35	UM	35	20	-	110	29	27	28	26	-	48	37	41	48	47	48
120	2.1	S	316201	32	L	37	22	-	120	27	29	37	27	-	42	41	49	52	50	48
121	2.1	S	877349	41	LM	35	20	-	118	26	30	33	29	-	45	41	52	53	55	52
122	2.1	SS	894302	45	LM	21	14	-	101	26	24	29	32	-	43	40	49	50	54	44
123	2.1	NS	848560	25	LM	21	21	-	116	23	32	32	29	-	46	50	52	49	40	44
124	2.1	BS	753892	36	UL	36	21	-	122	27	28	37	30	-	49	38	53	47	41	54
125	2.1	KS	8256004	42	LM	22	20	-	117	23	32	32	30	-	38	42	50	48	39	40
126	2.1	CS	76209	20	LM	22	15	-	98	20	27	30	21	-	46	43	48	56	41	40
127	2.1	ES	711532	52	UM	33	21	-	99	24	27	30	18	-	47	45	34	39	38	44
128	2.1	AS	918042	43	LM	35	15	-	103	26	24	31	32	-	38	43	35	40	38	46
129	2.1	SS	925867	47	LM	26	20	-	100	27	24	29	30	-	48	48	60	50	45	45
130	2.1	BS	863875	60	LM	22	16	-	123	28	28	37	30	-	30	45	48	52	42	45
131	2.1	KS	845614	35	LM	34	17	-	126	28	28	40	30	-	40	55	58	56	45	49
132	2.1	HS	848274	57	LM	23	17	-	116	23	32	32	29	-	46	39	46	49	56	52
133	2.1	R	874403	60	UM	25	17	-	124	28	28	37	30	-	44	56	45	46	43	51
134	2.1	J	906154	66	LM	30	19	-	124	28	28	38	29	-	48	42	45	40	40	39
135	2.1	J	873793	36	LM	25	16	-	111	24	26	32	29	-	47	49	51	53	48	52
136	2.1	MS	864357	42	UM	24	16	-	89	12	22	30	25	-	47	56	60	56	57	56

S. NO.	Gender	Initials	MRD	Age	SES	BDI	HAM-D	GHQ	STSS	ESP	CSS	STS	DS	CSI	EX	PR	VA	QU	EMO	IM
137	2.1	SS	946123	20	UL	22	20	-	119	25	31	33	30	-	39	46	24	19	35	49
138	2.1	AR	902433	52	LM	25	21	-	131	27	32	42	30	-	60	60	63	49	43	56
139	2.1	G	850573	66	UM	33	20	-	115	21	30	32	32	-	53	57	63	45	59	51
140	2.1	MK	789689	48	LM	29	15	-	102	26	24	31	31	-	45	43	50	52	42	48
141	2.1	DK	552288	46	LM	25	21	-	105	25	26	24	30	-	55	61	58	55	48	47
142	2.1	RS	983904	58	LM	32	19	-	120	26	31	34	29	-	38	40	56	57	52	58
143	2.1	RK	76549	34	LM	22	15	-	125	28	28	40	29	-	50	47	55	52	50	47
144	2.1	D	370011	35	LM	28	21	-	113	24	26	34	29	-	50	44	52	50	49	51
145	2.1	GS	862605	60	LM	28	18	-	122	28	27	38	28	-	48	49	50	51	47	48
146	2.1	BS	6054	66	LM	31	20	-	97	20	26	30	21	-	51	44	52	55	49	48
147	2.1	ML	1006198	36	LM	22	15	-	88	12	22	30	24	-	47	45	53	49	47	41
148	2.1	JS	9752677	42	LM	24	15	-	114	24	26	35	29	-	46	48	57	45	52	46
149	2.1	KS	424266	22	UL	29	16	-	127	28	28	42	29	-	49	45	60	53	40	48
150	2.1	A	890364	25	LM	27	14	-	121	26	30	36	29	-	52	45	57	47	58	58
151	2.1	YS	662413	33	LM	30	22	-	125	28	28	40	29	-	47	48	48	40	39	45
152	2.2	AJ	-	35	LM	-	-	11	100	24	25	32	29	-	52	41	30	37	32	40
153	2.2	AR	-	32	LM	-	-	11	102	24	25	35	28	-	64	40	39	44	42	40
154	2.2	RV	-	41	LM	-	-	10	96	20	25	30	21	-	54	51	44	40	44	39
155	2.2	MS	-	45	LM	-	-	12	98	20	26	31	21	-	67	55	45	42	39	35
156	2.2	KS	-	25	LM	-	-	9	80	12	26	19	23	-	55	41	40	38	34	30
157	2.2	GS	-	52	LM	-	-	10	99	20	26	31	21	-	66	41	37	30	33	30
158	2.2	HP	-	43	UL	-	-	11	99	20	26	31	21	-	58	39	47	45	33	29
159	2.2	KS	-	47	UL	-	-	12	97	20	26	30	21	-	55	52	51	39	37	32
160	2.2	GS	-	60	LM	-	-	12	95	20	24	30	21	-	69	42	36	39	37	40
161	2.2	AD	-	49	LM	-	-	5	91	19	23	29	20	-	55	53	50	40	38	41
162	2.2	US	-	33	LM	-	-	4	89	12	22	30	25	-	69	55	63	42	38	44
163	2.2	AS	-	35	LM	-	-	10	98	20	25	31	21	-	59	55	50	47	48	45
164	2.2	KS	-	57	LM	-	-	10	98	20	26	31	20	-	67	58	52	50	60	51
165	2.2	HS	-	60	LM	-	-	9	60	12	16	17	15	-	70	45	60	45	34	41
166	2.2	UB	-	66	LM	-	-	11	97	20	26	30	21	-	65	59	48	48	36	35
167	2.2	CS	-	48	LM	-	-	11	95	20	24	30	21	-	54	38	36	48	47	42
168	2.2	AS	-	46	LM	-	-	10	88	12	22	30	24	-	56	57	45	49	47	41
169	2.2	AS	-	58	LM	-	-	12	112	24	26	33	29	-	58	60	40	49	45	40
170	2.2	G	-	34	LM	-	-	6	86	12	22	33	25	-	49	48	47	49	45	43
171	2.2	MK	-	35	LM	-	-	10	89	12	22	30	25	-	60	46	59	48	45	40
172	2.2	DK	-	32	LM	-	-	12	91	19	23	29	20	-	59	49	41	38	40	39
173	2.2	RS	-	41	LM	-	-	11	95	20	24	30	21	-	58	48	57	37	39	64
174	2.2	RK	-	45	UL	-	-	10	96	20	24	31	21	-	70	57	58	50	59	42
175	2.2	D	-	34	UL	-	-	11	104	24	26	26	28	-	64	45	41	49	59	54
176	2.2	GS	-	35	UM	-	-	9	86	12	22	30	22	-	50	47	47	40	49	36
177	2.2	BS	-	60	LM	-	-	5	79	12	19	27	21	-	52	49	45	44	40	39
178	2.2	ML	-	66	LM	-	-	10	99	20	26	32	20	-	51	44	38	42	38	35
179	2.2	JS	-	36	UM	-	-	6	89	12	22	30	25	-	60	51	49	52	42	40
180	2.2	KS	-	42	LM	-	-	11	115	24	26	36	29	-	52	46	50	50	50	48
181	2.2	A	-	22	LM	-	-	11	111	24	26	29	32	-	50	36	67	53	48	50
182	2.2	HS	-	58	LM	-	-	10	106	25	30	27	25	-	68	55	47	45	45	43
183	2.2	GB	-	34	LM	-	-	10	99	20	26	32	20	-	68	52	49	53	46	49
184	2.2	GK	-	35	UM	-	-	10	98	20	26	31	20	-	68	49	45	50	53	50
185	2.2	SD	-	32	LM	-	-	9	84	18	20	33	19	-	57	48	42	45	44	41
186	2.2	AD	-	41	LM	-	-	12	100	25	27	29	29	-	49	52	50	41	34	40
187	2.2	MB	-	45	LM	-	-	5	70	15	16	24	15	-	70	58	52	51	49	53
188	2.2	AS	-	34	LM	-	-	10	101	26	24	35	26	-	49	56	46	46	36	40
189	2.2	HK	-	35	UM	-	-	8	83	14	21	25	23	-	49	49	40	44	38	40
190	2.2	MM	-	60	LM	-	-	11	117	25	32	33	27	-	49	49	55	52	39	45
191	2.2	PK	-	66	LM	-	-	4	80	12	26	19	23	-	62	58	38	40	38	42
192	2.2	K	-	48	LM	-	-	10	113	24	26	34	29	-	72	60	53	55	57	60
193	2.2	RB	-	46	UM	-	-	6	98	20	27	31	20	-	52	50	48	50	49	45
194	2.2	S	-	58	LM	-	-	8	85	13	21	31	20	-	56	35	42	40	36	40
195	2.2	AS	-	34	LM	-	-	2	76	15	20	22	19	-	50	52	49	47	35	36
196	2.2	AS	-	35	LM	-	-	5	71	15	16	25	15	-	59	49	51	53	33	35
197	2.2	S	-	58	LM	-	-	5	85	14	22	30	19	-	51	49	44	42	33	35
198	2.2	S	-	34	LM	-	-	2	84	14	21	30	19	-	59	55	44	41	34	35
199	2.2	SS	-	35	LM	-	-	8	91	19	20	32	20	-	61	53	54	56	39	41
200	2.2	NS	-	32	LM	-	-	2	71	17	15	25	14	-	55	53	51	50	40	36
201	2.2	BS	-	41	LM	-	-	6	84	14	19	31	20	-	54	49	41	49	38	34
202	2.2	KS	-	45	LM	-	-	2	70	16	17	23	14	-	61	56	50	54	54	48

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No. BFUHS/2K21p-TH/1624 **Date** 15/2/21

The Principal,
DMC,Ludhiana.

Subject: **Approval of Plan of Thesis.**

This is to inform you that the Faculty of Medical Sciences in its meeting held on 22.01.2021 has approved the plan of thesis of Dr. Tavleen Kaur, a student of your college for **M.Phil. (Clinical Psychology)** along with the names of Supervisor/Co-Supervisor as under:-

Topic Plan of Thesis
Comparative study on communication styles and silencing of self in individuals with and without depression

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Asst. Prof.,
Dept. of Clinical Psychology,

The student has to submit the three copies of thesis (along with PDF format) , to the Controller of Examinations, BFUHS, Faridkot, at least six months before the commencement of theory examination, if he/she is otherwise eligible to take the examination. He /She must directed to attach a photocopy of this letter with the forwarding letter while submitting thesis to the University along with the letter of approval of University for change of supervisor/Co-Supervisor, change of topic,(if any).

Dr. S P Singh MS(Oph)
Controller of Examinations

Note :

5. *If any discrepancy found regarding topic of thesis or Supervisor/Co-Supervisor, inform undersigned within one month after issue of this letter.*

COMPARATIVE STUDY ON COMMUNICATION STYLES AND SILENCING OF SELF IN INDIVIDUALS WITH AND WITHOUT DEPRESSION

THESIS PROPOSAL

FOR APPROVAL OF SUBJECT OF THESIS TO BE SUBMITTED

IN PARTIAL FULFILMENT OF THE REQUIREMENTS

FOR THE DEGREE OF

M.Phil.

in

CLINICAL PSYCHOLOGY

OF THE

BABA FARID UNIVERSITY OF HEALTH SCIENCES
FARIDKOT

June, 2020

Tavleen Kaur

DEPARTMENT OF CLINICAL PSYCHOLOGY
DAYANAND MEDICAL COLLEGE AND HOSPITAL
LUDHIANA

ABSTRACT OF PLAN OF THESIS

Title	COMPARATIVE STUDY ON COMMUNICATION STYLES AND SILENCING OF SELF IN INDIVIDUALS WITH AND WITHOUT DEPRESSION
For the degree of	M.PHIL. CLINICAL PSYCHOLOGY
Name of the candidate	Tavleen Kaur
Supervisor	Dr. Bholeshwar Prasad Mishra, Professor & Head, Department of Clinical Psychology, DMCH, Ludhiana
Co-supervisor	Dr. Pankaj Kumar, Associate Professor, Department of Psychiatry, DMCH, Ludhiana Ms. Palak Upadhyay, Assistant Professor, Department of Clinical Psychology, DMCH, Ludhiana
Institution	Dayanand Medical College & Hospital, Ludhiana
University	Baba Farid University of Health Sciences, Faridkot

Introduction: Communication style refers to the way in which one uses signals to process, interpret, filter, or understand literal meaning. Communication styles remains sufficiently patterned to create expectations. Jack's self-silencing theory holds that women form a self-concept based on participation in close relationships. When attempts to maintain or establish such relations fail, damaged self esteem and identity can result in pathological set of cognitive schemas. It has been conjectured that both of these variables play a role in depression.

Aim of Study: To study: 1. The gender differences between communication styles in individuals with and without depression. 2. The gender differences between silencing of self in individuals with and without depression. 3. The relationship between communication styles in individuals with and without depression. 4. The relationship between silencing of self in individuals with and without depression.

Materials & Methods: Information will be collected via– Predesigned socio-demographic proforma, Beck Depression Inventory, Hamilton Rating Scale for Depression, Communication Styles Inventory, The Silencing the Self Scale, The General Health Questionnaire - 12.

Clinical Significance: The study intends to find out the exact communication styles and self-silencing behaviours that play a role in persistence of depression.

Keywords: Communication styles, Silencing of self, depression, gender differences.

(Signature)	(Signature)	(Signature)	(Signature)	(Signature)
Candidate	Co-supervisor	Co-supervisor	Supervisor	Principal

CERTIFICATE OF FACILITIES AVAILABLE

This is to certify that the facilities for work on the subject of thesis titled **"COMPARATIVE STUDY ON COMMUNICATION STYLES AND SILENCING OF SELF IN INDIVIDUALS WITH AND WITHOUT DEPRESSION"** exist in the Department of Clinical Psychology, DMC&H, Ludhiana and will be provided to the candidate. We will see that the data being included in the thesis is genuine and is collected by the candidate herself under our supervision and guidance.

Supervisor

Dr. Bholeshwar Prasad Mishra
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Department of Clinical Psychology
DMCH, Ludhiana

Co-Supervisor

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Place : Ludhiana

Date : June 30, 2020

DR. B.P. MISHRA
Professor & Head
Dept. of Clinical Psychology
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APPROVAL PROFORMA
BY
RESEARCH & ETHICAL COMMITTEE
DAYANAND MEDICAL COLLEGE & HOSPITAL, LUDHIANA

Name of candidate	MS. TAVLEEN KAUR
Department	CLINICAL PSYCHOLOGY
Topic of Thesis	COMPARATIVE STUDY ON COMMUNICATION STYLES AND SILENCING OF SELF IN INDIVIDUALS WITH AND WITHOUT DEPRESSION
Likely date of appearing in PG examination	June 2021
Date of enrollment	23rd August, 2020
Name of Head of Department	Dr. Bholeshwar Prasad Mishra
1) Supervisor **2) Co-Supervisor(s)**	Dr. Bholeshwar Prasad Mishra Dr. Pankaj Kumar Ms. Palak Upadhyay
Signature of Members of Research Committee with Stamp	**Signature of Members of Ethics Committee with Stamp**
Dr. Jaspal Singh (Professor & Head, Surgery)	Mr. A K Jindal (Member, Ethics Committee)
Dr. Dinesh Gupta (Professor & Head, Medicine)	Dr. Anu Sharma (Professor, Anatomy)
Dr. Sandeep Kaushal (Assistant Dean Academics)	Dr. Deepinder K Chhina (Professor & Head, Microbiology)
Dr. Rajoo Singh Chhina (Dean Academics)	Dr. Neena Sood (Professor & Head, Pathology)
Dr. Gurpreet S Wander (Vice Principal)	Dr. Gurpreet S Wander (Vice Principal)
	Dr. Gagandeep Singh (Secretary, Ethics Committee Professor & Head, Neurology)

Approved: Yes / No

Dr. Sandeep Puri
Chairperson
Research Committee

Approved: Yes / ~~No~~

Prof. Arvind Malhotra
Chairperson
Ethics Committee

BABA FARID UNIVERSITY OF HEALTH SCIENCES, FARIDKOT

PROFORMA FOR REGISTRATION OF SUBJECT FOR DISSERTATION

1	NAME OF THE CANDIDATE AND ADDRESS	TAVLEEN KAUR NEAR FORT, NABHA, DISTT: PATIALA
2	NAME OF THE INSTITUTE	DAYANAND MEDICAL COLLEGE & HOSPITAL
3	COURSE OF STUDY AND SUBJECT	M.PHIL. CLINICAL PSYCHOLOGY
4	DATE OF ADMISSION OF COURSE	23rd AUGUST, 2019
5	TITLE OF THE TOPIC	COMPARATIVE STUDY ON COMMUNICATION STYLES AND SILENCING OF SELF IN INDIVIDUALS WITH AND WITHOUT DEPRESSION

6. BRIEF RESUME OF THE INTENDED WORK

6.1 NEED FOR THE STUDY

In a papyrus manuscript dated near the end of the third millennium B.C. the first recorded suicide threat was found. This marked the beginning of man's struggle with depression which, 4,000 years later, continues to bedevil scientists and clinicians alike. Mankind still is battling with the problem of depression and man being a social animal, it is imperative that factors associated with development and maintenance of depression be studied. Communication styles are known to influence the social experience of people, therefore making it an all-important facet to be studied. Silencing of self has been established to have strong relationship with depression, therefore making the assessment of this relationship imperative. Another important aspect is the different prevalence rates of depression among males and females. Needless to say these differing rates call for an in-depth investigation.

There are many ways in which interpersonal communication can be defined. Some scholars have defined interpersonal communication based on the situation and number of participants involved. This definition refers to the interaction between two individuals which are in proximity and are able to provide immediate feedback and utilize multiple senses. Interpersonal communication refers to the exchange of messages, verbal and nonverbal, between people, regardless of the relationship they share. Thus, interpersonal communication includes the exchange of messages in all sorts of relationships, ranging from functional to causal to intimate. These definitions all represent interpersonal communication as involving some form of mutual activity, interaction, or exchange, but they also differ significantly. Existing literature on communication styles does not give sufficient insights on manifestation, maintenance and gender differences in depression, thus calling for an in-depth assessment of these variables.

Caught between a need for close, empathic relationships and living in a culture that does not reward such an orientation, women learn to repress or silence part of their self. In other words, self-silencing grows as women adopt cultural schemas about their proper role and behavior in intimate relationships which run counter to their need for connectedness. Silencing behaviours include putting the needs of others first, censoring and repressing genuine emotion, and judging themselves by external standards. As such, self-denial and silencing lead to the eventual loss of self, and this loss renders one vulnerable to depression (and their respective symptoms) in women. Though the common viewpoint is that silencing of self is relatively common in women, some studies posit that men show equal and sometimes higher levels of self silencing. In the light of well-recognized differences between males and females with depression in relation to silencing of self, significance of this study lies in the fact that, there still is requirement of an in-detail assessment of this relationship in view of contradictory literature.

6.2 REVIEW OF LITERATURE

In the 1970s, Myrna Weissman underscored the gender difference in depression, noting that approximately twice as many females experience depression as males among adults in clinical and community samples (Weissman & Klerman, 1977).[1] Research consistently shows that women are twice as likely as men to develop depressive symptoms (Nolen-Hoeksema 1990).[2] The gender difference in depression represents a major health disparity.

Distressed couples with a depressed partner have been found generally to interact more negatively and less positively (Johnson & Jacob, 2000) [3], and to exhibit fewer problem–solving behaviors and to be less effective problem–solvers (Basco et al., 1992)[4] than distressed couples without a depressed partner. Shakeshaft (1989)[5] argues that when women communicate, their speech is less likely to be centered on impersonal subject matter, more on emotional and personal issues, and they talk less and listen more than men. In addition, the researcher shows that women's communication style has been considered as "deficient". Women's communicative styles are often equated with powerlessness while men's communicative styles are often associated with professionalism and power (Coates, 1996).[6] Academic research on psychological gender differences shows that while women use communication as a tool to enhance social connections and create relationships, men use language to exert dominance and achieve tangible outcomes (Maltz & Borker, 1982).[7] Women are, more expressive, tentative, and polite in conversation, while men are more assertive, and power-hungry (Basow & Rubenfield, 2003).[8]

One of the recent explanations for the sex differential is the silencing the self theory (Jack,1991)[9] which postulates that more women than men are depressed because of their greater tendency to self-silence in intimate relationships in order to preserve harmony and the relationship and to adhere to the traditional female role. Failure to attain and maintain intimate ties can result in feelings of shame, guilt, and depression (Gilligan, 1993).[10] Self-silencing, which involves the concealment of one's true feelings from others, can lead to a sense of

divided self where in the compliant self that is presented on the outside is incongruent with the personal feelings on the inside. The sense of divided self might be accompanied by feelings of anger and self-condemnation that can lead to heightened vulnerability for depression in some women (Jack, 1999).[11] Gender-specific prohibitions against displays of anger and aggression in females further discourage the expression of such feelings. Women are socialized to place a strong emphasis on relationships as they are a central component of the female sex role identity and emotional activity. Greater self-silencing in women has been found to relate to greater depression (Cramer, Gallant, & Langlois, 2005)[12] and greater perception of marital partner as critical or intolerant (Thompson et al, 2001).[13] Jack (1991)[9] conceptualized that self-silencing is not independent of the social structure rather is strongly rooted in the gender norms prescribed by the culture. This emerges from an attempt to 'fill a gender role marked by passivity, body shame, fear and vulnerability, and niceness' (Jack & Ali, 2010).[14] In many studies, men reported levels of self-silencing equal to those of women (Cowan, Bommersbach, & Curtis,1995)[15] or even higher than women's (Whiffen, Foot, & Thompson, 2007).[16] Researchers have also reported that, whereas men report significantly higher self-silencing than women, men also report lower depression (Duarte & Thompson, 1999).[17] These findings have led to the conclusion that further exploration of the reasons why men and women self-silence, and the consequences of this difference for psychological well-being, is needed (Cramer & Thoms, 2003).[18]

Besser et al. (2003)[19] examined the interrelation among self-silencing, depression, and loneliness. Respondents completed measures of loneliness, self-silencing, depressive experiences, as well as self-criticism, and dependency. After accounting for individual differences in depression, self-silencing acted as an important mediator in the relation between loneliness and self-criticism. The authors concluded that self-silencing offered a vital bridge between loneliness and depression. That some individuals keep distressing information to themselves makes it clear why depressive symptoms increase (Cramer, 1999).[20]

6.3 AIMS AND OBJECTIVES OF THE STUDY

To study:

1. The gender differences between communication styles in individuals with and without depression
2. The gender differences between silencing of self in individuals with and without depression.
3. The relationship between communication styles in individuals with and without depression.
4. The relationship between silencing of self in individuals with and without depression.

7. MATERIALS AND METHODS

7.1 Source of Data

The diagnosed patients of depression will be included from the outpatient and inpatient department of Psychiatry, Dayanand Medical College and Hospital, Ludhiana. The data for the control group will be collected from the general population.

7.2 METHOD OF COLLECTION OF DATA

Information shall be collected through questionnaires and socio-demographic details will be collected via pre-designed proforma for each individual that has been chosen to be a part of the study.

Socio demographic proforma, especially designed for present study to obtain the information regarding socio-demographic details, socioeconomic class (according to Kuppuswamy Socioeconomic scale), along with presenting complaints, past history of psychiatric illness and alcohol/drug abuse will be used.

The Beck Depression Inventory (BDI), developed by Beck, et al., 1961, is a 21- item, self-report rating inventory. It will be administered to measures characteristic attitudes and symptoms of depression. It is will be used to measure the frequency and intensity of depressive symptoms.

The Hamilton Rating Scale for Depression abbreviated as HAM-D (Hamilton, M. (1960)), is a clinician administered instrument. It will be administered to measure severity of depression in individuals.

Communication Styles Inventory (CSI), consisting of 96, items which has its roots in a lexical study on communication styles (De Vries, Bakker-Pieper, Alting Siberg, Van Gameren, Vlug, 2009) will be administered to assess the communication styles of individuals. These different facets of the questionnaire are named Expressiveness, Preciseness, Verbal Aggressiveness, Questioningness, Emotionality and Impression Manipulativeness.

The Silencing the Self Scale (STSS), by Dana Crowley Jack (1991), consisting of 31 items will be administered. The subscales of this scale

are externalized self-perception, care as self-sacrifice, silencing the self and divided self.

The General Health Questionnaire - 12 (GHQ - 12), developed by Goldberg in 1970s will be administered to detect individuals who are at a risk of developing psychiatric disorders. It has been divided into four subscales: somatic symptoms, anxiety/insomnia, social dysfunction and severe depression.

INCLUSION CRITERIA FOR STUDY GROUP-

1. Individuals of either gender will be selected for the study.
2. The patients with a diagnosis of moderate depression.
3. The patients with a diagnosis of severe depression.

EXCLUSION CRITERIA FOR STUDY GROUP-

1. Individuals of either gender having a diagnosis of mild depression.
2. Individuals with any other major Psychiatric Illness.
3. Individuals with any organic illness/condition.

INCLUSION CRITERIA FOR CONTROL GROUP-

1. Individuals of either gender will be selected for the study.
2. The individuals without a diagnosis of moderate depression.
3. The individuals without a diagnosis of severe depression.

EXCLUSION CRITERIA FOR CONTROL GROUP-

1. Individuals of either gender having a diagnosis of mild depression.
2. Individuals with any other major Psychiatric illness.
3. Individuals with any organic illness/condition.

METHODS OF COLLECTION

The study will be conducted on patients undergoing treatment for depression (for study group) and on those who are not diagnosed with or undergoing treatment for depression (for control group).

The candidates for the study group will be selected based on their diagnosis and scores on The Beck Depression Inventory and The Hamilton Rating Scale for Depression. The candidates for the control group will be selected based on their score on The General Health Questionnaire-12.

SAMPLE SIZE: A total of 200 subjects of either gender, of age range 18-60 years will be selected. A total of 100 subjects (50 males and 50

females) will constitute the study group and a total of 100 subjects (50 males and 50 females) will constitute the control group.

DURATION OF STUDY: NONE

OUTCOME

To find out the differences in communication styles used and silencing of self in individuals with and without depression. To find out the gender difference between communication styles used and silencing of self done by depressed and non-depressed individuals of either gender.

STATISTICAL ANALYSIS

Data will be described in terms of range; mean ±standard deviation (± SD), median, frequencies (number of cases) and relative frequencies (percentages) as appropriate. Comparison of quantitative variables between the study groups will be done using Student t-test and Mann Whitney U test for independent samples for parametric and non-parametric data respectively. For comparing categorical data, Chi square ($\chi 2$) test will be performed and exact test will be used when the expected frequency is less than 5. A probability value (p value) less than 0.05 was considered statistically significant. A probability value (p value) less than 0.05 will be considered statistically significant. All statistical calculations will be done using SPSS (Statistical Package for the Social Science) SPSS 21 version statistical program for Microsoft Windows.

7.3 DOES THE STUDY REQUIRE ANY INVESTIGATIONS OR INTERVENTIONS TO BE CONDUCTED ON PATIENTS OR OTHER HUMANS OR ANIMALS? IF SO, PLEASE DESCRIBE BRIEFLY.

NONE.

7.4 HAS ETHICAL CLEARANCE BEEN OBTAINED FROM YOUR INSTITUTION IN CASE OF 7.3?

ATTACHED HEREWITH

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APPENDICES

APPENDIX A: INFORMED PATIENT CONSENT

Date: _____

I.....D/o, W/o, S/o..... .....am willing to participate in the study **"COMPARATIVE STUDY ON COMMUNICATION STYLES AND SILENCING OF SELF IN INDIVIDUALS WITH AND WITHOUT DEPRESSION".** The procedure with its complications has been explained to me in local vernacular language. I have fully understood that no special tests and extra expenditure in any form, merely for the purpose of thesis is being carried out. I am free to opt out the study any time without assigning any reason.

.....
Signature of the Witness
Name:

.....
Signature of the patient

Signature of Candidate

Signature of Supervisor

मरीज अनुमति फार्म

तिथि_____

मैं_____ पत्नी/पुत्र/ पुत्री_____

निवासी_____ इस

शोधकार्य"COMPARATIVE STUDY ON COMMUNICATION STYLES AND SILENCING OF SELF IN INDIVIDUALS WITH AND WITHOUT DEPRESSION" लेने भाग में शोधकार्य इस मैं हूँ। सहमत लिए के लेने भाग में करता पुष्टि मैं हूँ। तैयार से स्वेच्छा अपनी लिए के/ देने स्वीकृति यह की हूँ करती गया डाला दबाव ही न और गया दिया नहीं प्रलोभन आर्थिक कोई मुझे लिए के सविश्वा यह मुझे और है गया दिया कर स्पष्ट श्यउद्दे का शोधकार्य इस मुझे है। होने में शोधकार्य इस मुझे है। लिए के लाभ के मानवता और विज्ञान यह की है जोखिम यह में समझ मेरी और है गया दिया समझा में बारे के जोखिम वाले है। मामुली बहुत

अपनी समय भी किसी में सम्बन्ध के लेने भाग में शोधकार्य इस मैं कतास कर व्यक्त अस्वीकृति/ मेरे का करने व्यक्त अस्वीकृति मेरे और हूँ सकती पड़ेगा। नहीं प्रभाव कोई पर इलाज

_____ _____

हस्ताक्षर के गवाह हस्ताक्षर के रोगी/ निशान का अंगूठे

नाम: नाम:

_____

अन्वेषक केहस्ताक्षर

_____

हस्ताक्षर के विद्यार्थी

ਮਰੀਜ਼ ਰਜ਼ਾਮੰਦੀ ਫ਼ਾਰਮ

ਮਿਤੀ_____

ਮੈ_____ਪਤਨੀ/ਪੁੱਤਰ/ਪੁੱਤਰੀ_____

ਵਾਸੀ _____

"COMPARATIVE STUDY ON COMMUNICATION STYLES AND SILENCING OF SELF IN INDIVIDUALS WITH AND WITHOUT DEPRESSION" ਤੇ ਚਲ ਰਹੀ ਖੋਜ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਲਈ ਰਜ਼ਾਮੰਦ ਹਾਂ। ਇਸ ਖੋਜ ਕੰਮ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਲਈ ਮੈ ਆਪਣੀ ਮਰਜ਼ੀ ਨਾਲ ਤਿਆਰ ਹਾਂ। ਮੈ ਇਹ ਦਸਣਾ ਚਾਹੁੰਦਾ ਹਾਂ/ ਚਾਹੁੰਦੀ ਹਾਂ ਕੇ ਇਹ ਰਜ਼ਾਮੰਦੀ ਦੇਣ ਵਾਸਤੇ ਮੈਨੂ ਕਿਸੇ ਵੀ ਤਰਾਂ ਦਾ ਲੋਭ-ਲਾਲਚ ਨਹੀ ਦਿੱਤਾ ਗਿਆ ਅਤੇ ਨਾ ਹੀ ਕੋਈ ਦਬਾ ਪਾਇਆ ਗਿਆ ਹੈ। ਮੈਨੂ ਇਸ ਖੋਜ ਦਾ ਮਨੋਰਥ ਸਮਝਾ ਦਿੱਤਾ ਗਿਆ ਹੈ ਅਤੇ ਮੈਨੂ ਇਹ ਭਰੋਸਾ ਦਵਾਇਆ ਗਿਆ ਹੈ ਕੇ ਇਹ ਖੋਜ ਵਿਗਿਆਨ ਅਤੇ ਮਾਨਵਤਾ ਦੀ ਭਲਾਈ ਲਈ ਹੈ। ਮੈਨੂ ਇਸ ਖੋਜ ਵਿਚ ਹੋਣ ਵਾਲੇ ਖਤਰੇ ਬਾਰੇ ਸਮਝਾ ਦਿੱਤਾ ਗਿਆ ਹੈ ਅਤੇ ਮੈਨੂ ਇਹ ਯਕੀਨ ਹੈ ਕੇ ਇਹ ਖਤਰਾ ਬਹੁਤ ਮਾਮੂਲੀ ਹੈ। ਮੈਨੂ ਇਸ ਖੋਜ ਕੰਮ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਦਾ ਢੰਗ-ਤਰੀਕਾ ਸਮਝਾ ਦਿੱਤਾ ਗਿਆ ਹੈ।

ਮੈ ਇਸ ਖੋਜ ਕੰਮ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਬਾਰੇ ਆਪਣੀ ਰਜ਼ਾਮੰਦੀ ਕਿਸੇ ਵੀ ਸਮੇ ਵਾਪਸ ਲੈ ਸਕਦਾ ਹਾਂ/ ਸਕਦੀ ਹਾਂ ਅਤੇ ਮੇਰੀ ਰਜ਼ਾਮੰਦੀ ਵਾਪਸ ਲੈਣ ਦਾ ਮੇਰੇ ਇਲਾਜ ਤੇ ਕੋਈ ਅਸਰ ਨਹੀ ਹੋਵੇਗਾ।

_____

ਗਵਾਹਦੇਹਸਤਾਖਰ

ਮਿਤੀ_____

ਪਤਾ _____

_____

ਮਰੀਜ਼ਦੇਹਸਤਾਖਰ

ਮਿਤੀ_____

ਪਤਾ _____

_____

ਨਿਰੀਖਕਦੇ ਹਸਤਾਖਰ

_____

ਸਿਖਿਆਰਥੀ ਦੇ ਹਸਤਾਖਰ

APPENDIX B: PROFORMA FOR HISTORY TAKING

Name: **Date:**
MRD:
Age:
Gender: a) Male b) Female
Contact No.:
Education: a) Illiterate b) Primary c) Middle d) 10^{th} e)12^{th} f) Graduate g) Postgraduate
Occupation: a) Unemployed b) Unskilled worker c) Semi-skilled worker d) Skilled worker e) Clerical/Shopkeeper/Farmer f) Professional g) Housewife/Household h) Student i) Retired
Marital Status: a) Single b) Married c) Unmarried d) Divorced e) Separated
Locality: a) Rural b) Urban
Religion: a) Hindu b) Sikh c) Muslim d) Christian e) Other
Family type: a) Nuclear b) Extended c) Joint d) Other e) Not Known
Head of the family – a) Name:
b) Age:
c) Education:
d) Occupation:
e) Income in Rs/Month:
Chief Complaints: _____
_____
_____
_____

Past Psychiatric history:

Alcohol/ Drug use: a) Yes b) No

Socioeconomic Class:

I. Upper
II. Upper middle
III. Lower middle
IV. Upper lower
V. Lower

APPENDIX C: BECK'S DEPRESSION INVENTORY (BDI)

1.

0 I do not feel sad.
1 I feel sad
2 I am sad all the time and I can't snap out of it.
3 I am so sad and unhappy that I can't stand it.

2.

0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel the future is hopeless and that things cannot improve.

3.

0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.

4.

0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

5.

0 I don't feel particularly guilty
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6.

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7.

0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

8.

0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

9.

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10.

0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

11.

0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.

0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.

0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.

0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.

15.

0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.

0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.

0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18.

0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19.

0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.

0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21.

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely.

APPENDIX D: HAMILTON RATING SCALE FOR DEPRESSION (HAM-D)

Patient Name _____

Today's Date _____

The HAM-D is designed to rate the severity of depression in patients.

1. DEPRESSED MOOD (Gloomy attitude, pessimism about the future, feeling of sadness, tendency to weep)
   - 0 = Absent
   - 1 = Sadness, etc.
   - 2 = Occasional weeping
   - 3 = Frequent weeping
   - 4 = Extreme symptoms
2. FEELINGS OF GUILT
   - 0 = Absent
   - 1 = Self-reproach, feels he/she has let people down
   - 2 = Ideas of guilt
   - 3 = Present illness is a punishment; delusions of guilt
   - 4 = Hallucinations of guilt
3. SUICIDE
   - 0 = Absent
   - 1 = Feels life is not worth living
   - 2 = Wishes he/she were dead
   - 3 = Suicidal ideas or gestures
   - 4 = Attempts at suicide
4. INSOMNIA - Initial (Difficulty in falling asleep)
   - 0 = Absent
   - 1 = Occasional
   - 2 = Frequent
5. INSOMNIA - Middle (Complains of being restless and disturbed during the night. Waking during the night.)
   - 0 = Absent
   - 1 = Occasional
   - 2 = Frequent
6. INSOMNIA - Delayed (Waking in early hours of the morning and unable to fall asleep again)
   - 0 = Absent
   - 1 = Occasional
   - 2 = Frequent

7. WORK AND INTERESTS

0 = No difficulty

1 = Feelings of incapacity, listlessness, indecision and vacillation

2 = Loss of interest in hobbies, decreased social activities

3 = Productivity decreased

4 = Unable to work. Stopped working because of present illness only. (Absence from work after treatment or recovery may rate a lower score).

8. RETARDATION (Slowness of thought, speech, and activity; apathy; stupor.)

0 = Absent

1 = Slight retardation at interview

2 = Obvious retardation at interview

3 = Interview difficult

4 = Complete stupor

9. AGITATION (Restlessness associated with anxiety.) \

0 = Absent

1 = Occasional

2 = Frequent

10. ANXIETY - PSYCHIC

0 = No difficulty

1 = Tension and irritability

2 = Worrying about minor matters

3 = Apprehensive attitude

4 = Fears

11. ANXIETY - SOMATIC Gastrointestinal, indigestion Cardiovascular, palpitation, Headaches Respiratory, Genito-urinary, etc.

0 = Absent 1 = Mild

2 = Moderate

3 = Severe

4 = Incapacitating

12. SOMATIC SYMPTOMS - GASTROINTESTINAL (Loss of appetite , heavy feeling in abdomen; constipation)

0 = Absent

1 = Mild

2 = Severe

13. SOMATIC SYMPTOMS - GENERAL (Heaviness in limbs, back or head; diffuse backache; loss of energy and fatiguability)

0 = Absent

1 = Mild

2 = Severe

14. GENITAL SYMPTOMS (Loss of libido, menstrual disturbances)

0 = Absent

1 = Mild

2 = Severe

15. HYPOCHONDRIASIS

0 = Not present

1 = Self-absorption (bodily)

2 = Preoccupation with health

3 = Querulous attitude

4 = Hypochondriacal delusions

16. WEIGHT LOSS

0 = No weight loss

1 = Slight

2 = Obvious or severe

17. INSIGHT (Insight must be interpreted in terms of patient's understanding and background.)

0 = No loss

1 = Partial or doubtful loss

2 = Loss of insight

18. DIURNAL VARIATION (Symptoms worse in morning or evening. Note which it is.)

0 = No variation

1 = Mild variation; AM ( ) PM ( )

2 = Severe variation; AM ( ) PM ( )

19. DEPERSONALIZATION AND DEREALIZATION (feelings of unreality, nihilistic ideas)

0 = Absent

1 = Mild

2 = Moderate

3 = Severe

4 = Incapacitating

20. PARANOID SYMPTOMS (Not with a depressive quality)

0 = None

1 = Suspicious

2 = Ideas of reference

3 = Delusions of reference and persecution

4 = Hallucinations, persecutory

21. OBSESSIONAL SYMPTOMS (Obsessive thoughts and compulsions against which the patient struggles)

0 = Absent

1 = Mild

2 = Severe

APPENDIX E: COMMUNICATION STYLES INVENTORY (CSI)

1 – Completely disagree; 2 – Disagree; 3 – Neutral; 4 – Agree; 5 – Completely agree

1. I always have a lot to say.
   1 2 3 4 5
2. When I tell a story, the different parts are always clearly related to each other.
   1 2 3 4 5
3. If something displeases me, I sometimes explode with anger.
   1 2 3 4 5
4. I sometimes toss bizarre ideas into a group discussion.
   1 2 3 4 5
5. When I see others cry, I have difficulty holding back my tears.
   1 2 3 4 5
6. I sometimes praise somebody at great length, without being really genuine in order to make them like me.
   1 2 3 4 5
7. I often take the lead in a conversation.
   1 2 3 4 5
8. I think carefully before I say something.
   1 2 3 4 5
9. I am not very likely to tell someone what they should do.
   1 2 3 4 5
10. I never enter into discussions about the future of the human race.
    1 2 3 4 5
11. When I'm worried about something, I find it hard to talk about anything else.
    1 2 3 4 5
12. I sometimes use my charm to get something done.
    1 2 3 4 5
13. Because of my humor, I'm often the centre of attention among a group of people.
    1 2 3 4 5
14. Conversations with me always involve some important topic.
    1 2 3 4 5
15. I never make fun of anyone in a way that might hurt their feelings.
    1 2 3 4 5
16. During a conversation, I always try to find out about the background of somebody's opinion.
    1 2 3 4 5
17. Because of stress, I am sometimes unable to express myself properly.
    1 2 3 4 5

18. I make sure that people cannot read it from my face when I don't appreciate them.
1 2 3 4 5
19. I communicate with others in a distant manner.
1 2 3 4 5
20. I don't need a lot of words to get my message across.
1 2 3 4 5
21. I can listen well.
1 2 3 4 5
22. To stimulate discussion, I sometimes express a view different from that of my conversation partner.
1 2 3 4 5
23. The comments of others have a noticeable effect on me.
1 2 3 4 5
24. I sometimes conceal information to make me look better.
1 2 3 4 5
25. I have a hard time keeping myself silent when around other people.
1 2 3 4 5
26. I sometimes find it hard to tell a story in an organized way.
1 2 3 4 5
27. Even when I'm angry, I won't take it out on someone else.
1 2 3 4 5
28. I often say unexpected things.
1 2 3 4 5
29. During a conversation, I am not easily overcome by emotions.
1 2 3 4 5
30. In discussions I sometimes express an opinion I do not support in order to make a good impression.
1 2 3 4 5
31. Most of the time, other people determine what the discussion is about, not me.
1 2 3 4 5
32. I weigh my answers carefully.
1 2 3 4 5
33. I sometimes insist that others do what I say.
1 2 3 4 5
34. I like to talk with others about the deeper aspects of our existence.
1 2 3 4 5
35. I tend to talk about my concerns a lot.
1 2 3 4 5
36. I sometimes flirt a little bit to win somebody over.
1 2 3 4 5

37. I have a hard time being humorous in a group.
1 2 3 4 5

38. You won't hear me jabbering about superficial or shallow matters.
1 2 3 4 5

39. I have at times made people look like fools.
1 2 3 4 5

40. I don't bother asking a lot of questions just to find out why people feel the way they do about something.
1 2 3 4 5

41. I can be visibly tense during a conversation.
1 2 3 4 5

42. Even when people ask for my thoughts on something, I seldom speak my mind if those thoughts are unacceptable for others.
1 2 3 4 5

43. I behave somewhat formally when I meet someone.
1 2 3 4 5

44. Most of the time, I only need a few words to explain something.
1 2 3 4 5

45. I always show a lot of understanding for other people's problems.
1 2 3 4 5

46. I like to provoke others by making bold statements.
1 2 3 4 5

47. Nasty remarks from other people do not bother me too much.
1 2 3 4 5

48. I sometimes 'forget' to tell something when this is more convenient for me. **1 2 3 4 5**

49. I am never the one who breaks a silence by starting to talk.
1 2 3 4 5

50. I always express a clear chain of thoughts when I argue a point.
1 2 3 4 5

51. I tend to snap at people when I get annoyed.
1 2 3 4 5

52. In discussions, I often put forward unusual points of view.
1 2 3 4 5

53. When describing my memories, I sometimes get visibly emotional.
1 2 3 4 5

54. Sometimes I use flattery to get someone in a favorable mood.
1 2 3 4 5

55. I often determine which topics are talked about during a conversation.
1 2 3 4 5

56. The statements I make are not always well thought out.
1 2 3 4 5

57. I expect people to obey when I ask them to do something.
1 2 3 4 5

58. I never engage in so-called philosophical conversations.
1 2 3 4 5

59. People can tell when I feel anxious.
1 2 3 4 5

60. I would not use my appearance to make people do things for me.
1 2 3 4 5

61. My jokes always draw a lot of attention.
1 2 3 4 5

62. I am someone who can often talk about trivial things.
1 2 3 4 5

63. I have been known to be able to laugh at people in their face.
1 2 3 4 5

64. I ask a lot of questions to uncover someone's motives.
1 2 3 4 5

65. I am able to address a large group of people very calmly.
1 2 3 4 5

66. I am able to hide negative feelings about other people well.
1 2 3 4 5

67. I address others in a very casual way.
1 2 3 4 5

68. I am somewhat long-winded when I need to explain something.
1 2 3 4 5

69. I always take time for someone if they want to talk to me.
1 2 3 4 5

70. I try to find out what people think about a topic by getting them to debate with me about it. **1 2 3 4 5**

71. When people criticize me, I am visibly hurt.
1 2 3 4 5

72. I tell people the whole story, even when this is probably not good for me.
1 2 3 4 5

73. I like to talk a lot.
1 2 3 4 5

74. My stories always contain a logical structure.
1 2 3 4 5

75. I can sometimes react somewhat irritably to people.
1 2 3 4 5

76. In conversations, I often toy with some very wild ideas.
1 2 3 4 5

77. People can tell that I am emotionally touched by some topics of conversation.
1 2 3 4 5

78. To be considered likeable, I sometimes say things my conversation partner likes to hear.
1 2 3 4 5

79. I often determine the direction of a conversation.
1 2 3 4 5

80. I choose my words with care.
1 2 3 4 5

81. When I feel others should do something for me, I ask for it in a demanding tone of voice.
1 2 3 4 5

82. I regularly have discussions with people about the meaning of life.
1 2 3 4 5

83. When I worry, everybody notices.
1 2 3 4 5

84. I sometimes put on a very seductive voice when I want something.
1 2 3 4 5

85. I often manage to make others burst out laughing.
1 2 3 4 5

86. I rarely if ever just chatter away about something.
1 2 3 4 5

87. I have humiliated someone in front of a crowd.
1 2 3 4 5

88. I always ask how people arrive at their conclusions.
1 2 3 4 5

89. I find it hard to talk in a relaxed manner when what I have to say is valued highly.
1 2 3 4 5

90. Other people can easily tell when I think badly about them.
1 2 3 4 5

91. I come across as somewhat stiff when dealing with people.
1 2 3 4 5

92. With a few words I can usually clarify my point to everybody.
1 2 3 4 5

93. I always treat people with a lot of respect.
1 2 3 4 5

94. By making controversial statements, I often force people to express a clear opinion.

1 2 3 4 5

95. I am not always able to cope easily with critical remarks.
1 2 3 4 5

96. Even if I would benefit from withholding information from someone, I would find it hard to do so.
1 2 3 4 5

APPENDIX F: SILENCING THE SELF SCALE (STSS)

Please circle the number that best describes how you feel about each of the statements listed below. If you are not currently in an intimate relationship, please indicate how you felt and acted in your previous intimate relationships.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

1. I think it is best to put myself first because no one else will look out for me.

   1 2 3 4 5

2. I don't speak my feelings in an intimate relationship when I know they will cause disagreement.

   1 2 3 4 5

3. Caring means putting the other person's needs in front of my own.

   1 2 3 4 5

4. Considering my needs to be as important as those of the people I love is selfish.

   1 2 3 4 5

5. I find it is harder to be myself when I am in a close relationship than when I am on my own.

   1 2 3 4 5

6. I tend to judge myself by how I think other people see me.

   1 2 3 4 5

7. I feel dissatisfied with myself because I should be able to do all the things people are supposed to be able to do these days.

   1 2 3 4 5

8. When my partner's needs and feelings conflict with my own, I always state mine clearly.

   1 2 3 4 5

9. In a close relationship, my responsibility is to make the other person happy.

1 2 3 4 5

10. Caring means choosing to do what the other person wants, even when I want to do something different.

1 2 3 4 5

11. In order to feel good about myself, I need to feel independent and self-sufficient.

1 2 3 4 5

12. One of the worst things I can do is to be selfish.

1 2 3 4 5

13. I feel I have to act in a certain way to please my partner.

1 2 3 4 5

14. Instead of risking confrontations in close relationships, I would rather not rock the boat.

1 2 3 4 5

15. I speak my feelings with my partner, even when it leads to problems or disagreements.

1 2 3 4 5

16. Often I look happy enough on the outside, but inwardly I feel angry and rebellious.

1 2 3 4 5

17. In order for my partner to love me, I cannot reveal certain things about myself to him/her.

1 2 3 4 5

18. When my partner's needs or opinions conflict with mine, rather than asserting my own point of view I usually end up agreeing with him/her.

1 2 3 4 5

19. When I am in a close relationship I lose my sense of who I am.

1 2 3 4 5

20. When it looks as though certain of my needs can't be met in a relationship, I usually realize that they weren't very important anyway.

1 2 3 4 5

21. My partner loves and appreciates me for who I am.

1 2 3 4 5

22. Doing things just for myself is selfish.

1 2 3 4 5

23. When I make decisions, other people's thoughts and opinions influence me more than my own thoughts and opinions.

1 2 3 4 5

24. I rarely express my anger at those close to me.

1 2 3 4 5

25. I feel that my partner does not know my real self.

1 2 3 4 5

26. I think it's better to keep my feelings to myself when they do conflict with my partner's.

1 2 3 4 5

27. I often feel responsible for other people's feelings.

1 2 3 4 5

28. I find it hard to know what I think and feel because I spend a lot of time thinking about how other people are feeling.

1 2 3 4 5

29. In a close relationship I don't usually care what we do, as long as the other person is happy.

1 2 3 4 5

30. I try to bury my feelings when I think they will cause trouble in my close relationship(s).

1 2 3 4 5

*31. I never seem to measure up to the standards I set for myself.

1 2 3 4 5

* If you answered the last question with a 4 or 5, please list up to three standards you feel you don't measure up to.

1.

2.

3.

4.

APPENDIX G: GENERAL HEALTH QUESTIONNAIRE -12 (GHQ-12)

We want to know how your health has been in general over the last few weeks. Please read the questions below and each of the four possible answers. Circle the response that best applies to you. Thank you for answering all the questions.

Have you recently:

1. Been able to concentrate on what you're doing?

Better than usual	same as usual	less than usual	much less than usual
(0)	(1)	(2)	(3)

2. Lost much sleep over worry?

Not at all	no more than usual	rather more than usual	much more than usual
(0)	(1)	(2)	(3)

3. Felt that you are playing a useful part in things?

More so than usual	same as usual	less so than usual	much less than usual
(0)	(1)	(2)	(3)

4. Felt capable of making decisions about things?

More so than usual	same as usual	less than usual	much less than usual
(0)	(1)	(2)	(3)

5. Felt constantly under strain?

Not at all	no more than usual	rather more than usual	much more than usual
(0)	(1)	(2)	(3)

6. Felt you couldn't overcome your difficulties?

Not at all	no more than usual	rather more than usual	much more than usual
(0)	(1)	(2)	(3)

7. Been able to enjoy your normal day to day activities?

More so than usual (0) | same as usual (1) | less so than usual (2) | much less than usual (3)

8. Been able to face up to your problems?

More so than usual (0) | same as usual (1) | less than usual (2) | much less than usual (3)

9. Been feeling unhappy or depressed?

Not at all (0) | no more than usual (1) | rather more than usual (2) | much more than usual (3)

10. Been losing confidence in yourself?

Not at all (0) | no more than usual (1) | rather more than usual (2) | much more than usual (3)

11. Been thinking of yourself as a worthless person?

Not at all (0) | no more than usual (1) | rather more than usual (2) | much more than usual (3)

12. Been feeling reasonably happy, all things considered?

More so than usual (0) | same as usual (1) | less so than usual (2) | much less than usual (3)